GM NATIONAL BENEFIT CENTER
NAO Personnel Administration
P.O. Box 5175
Southfield, MI 48086-5175
1-800-435-3946
TDD: 1-800-872-8682

May 10, 1995

Mr. Paul J. Dobosz
104 E. Pelican Avenue
McAllen, TX 78504-1991

383-50-4752

Dear Mr. Dobosz:

Pursuant to our May 10, 1995 conversation, enclosed please find the General Motors Salaried Health Care Program language.

If you have any questions, please contact me at the number listed above.

Sincerely,

Kerri Sattler
Correspondence and Appeals Unit
GM National Benefit Center

Enclosure

THE GENERAL MOTORS SALARIED HEALTH CARE PROGRAM

January 1, 1994

SALARIED HEALTH CARE PROGRAM

ARTICLE I
ESTABLISHMENT, FINANCING AND
ADMINISTRATION OF THE SALARIED HEALTH CARE PROGF

Section 1. Establishment and Effective Date of the Program

(a) Establishment of the Program

General Motors Corporation, on behalf of itself and its Divisions and Groups and as agent for certain of its directly or indirectly wholly-owned and substantially wholly-owned domestic subsidiaries, will establish a Salaried Health Care Program, hereinafter referred to as the Program or this Program, either through a self-insured plan or by other arrangement.

(b) Reservation of Rights

(1) The Corporation reserves the right to amend, modify, suspend or terminate the Program in whole or in part, at any time, by action of its Board of Directors or other committee expressly authorized by the Board to take such action. No enrollee described in this Program may be deemed to have any vested right to continued coverage under any or all of the provisions of the Program.

(2) No oral or written statements can change the terms of this Program. This Program can only be amended by an appropriate committee as designated by the Board of Directors. Absent an express delegation of authority from the Board of Directors, no one has the authority to commit the Corporation to any benefit or benefit provision not provided for under the Program or to change the eligibility criteria or other provisions of the Program.

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Art. I, 1(b)(3)

(3) In the event the initiation of any benefit(s) or coverage(s) described in the Program does not prove practicable or if the carriers are unable to provide such benefit(s) or coverage(s) on the dates stipulated in such Program, the Corporation may provide new, different or no benefit(s) and/or coverage(s).

(c) Effective Date

This Program is effective January 1, 1994. Until January 1, 1994, the provisions of the prior Program were in effect unless expressly indicated otherwise. This Program shall continue in effect until amended, modified, suspended or terminated by the Corporation as specified above.

Section 2. Corporation Costs and Administrative Items

(a) Net Costs

(1) The Corporation, or a trust, shall pay the balance of the net cost of the Program over and above any enrollee contributions or payments specified under the Program. The Corporation shall receive and retain any credits, refunds, or reimbursements under whatever name, arising out of the Program.

(2) The Corporation, by payment of its contributions (whether by paying claims through carriers administering the Program or by any other manner) shall be relieved of any further liability with respect to the coverage(s) or benefit(s) provided under the Program, except as otherwise may be required by the Employee Retirement Income Security Act of 1974, as amended.

SALARIED HEALTH CARE PROGRAM

Art. I, 2(a)(3)

(3) Certain enrollees may be offered choic amc g various health care options. The perf ance of options may be evaluated by the Corpor ion. Contributions by enrollees may be req red to participate in the Program, or in an ption, and may be based on the status of the pr ary enrollee, the number of covered enro..ees, the Medicare status of enrollees and the relative performance of the options available or elected. To the extent permitted by law, such required enrollee contributions shall be by payroll or other similar deduction.

(4) Subject to the Corporation's reserved right to amend, modify or terminate the Program, the Corporation will share future Program cost increases with enrollees, on an aggregate basis to be determined by the Corporation, on a basis of 75% Corporation-paid and 25% enrollee-paid. Such enrollee cost sharing may be in the form of monthly contributions, deductibles, copayments, other design changes or any combination of the preceding.

(b) Administration

(1) General Motors Corporation is the Plan Administrator. The Plan Administrator has discretionary authority to construe, interpret, apply and administer the Program. The Plan Administrator may delegate various aspects of Program administration as it deems appropriate.

(2) Various aspects of Program administration have been delegated to carriers. In carrying out their delegated responsibilities, the carriers shall have discretionary authority to construe, interpret, apply and administer the Program provisions. The discretionary authority legated to a carrier shall, however, be limited t. Program terms relevant to its delegated responsibi ties, and shall not permit a carrier to render a determination or make any representation concerning benefits which are not provided by the express terms of the Program. The carriers' actions shall be given full force and effect unless determined by the Plan Administrator to be contrary to the Program provisions or arbitrary and capricious.

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SALARIED HEALTH CARE PROGRAM

Art. I, 2(e)

(e) Time Limit for Claim Submission

Claims should be filed with the appropriate carrier as services are rendered and expenses are incurred. However, claims must be submitted not later than the end of the calendar year following the year in which services are rendered.

(f) Assignment or Alienation of An Enrollee's Interests

Except as expressly authorized by this Program or as required to comply with the legally applicable provisions of a Qualified Medical Child Support Order under the Omnibus Budget Reconciliation Act of 1993, benefits, claims, coverage or other interests in the Program may not be assigned, transferred or alienated by an enrollee. With the approval of the Corporation however, a carrier may pay a provider directly for services rendered, in lieu of payment to an enrollee.

Section 3. Program in States With Health Insurance Laws

(a) To the extent the Corporation and the Program are not required, under Federal law, to comply with state-legislated mandates concerning health insurance coverages, the provisions of this Program need not be modified in states having laws which now or hereafter may provide health care coverages, under whatever name, for enrollees who are disabled by non-occupational sickness or accident, or similar disability. If, under Federal law, the Corporation and the Program are subject to state-legislated mandates, compliance with such laws shall be deemed full compliance with the provisions of the Program with respect to enrollees in such states. If coverage under such state-legislated mandates exceeds the coverage provided under the Program, the Corporation may require such contributions as it may deem appropriate from enrollees in such states. If appropriate coverage under such state-legislated mandates is generally lower in level than the corresponding coverage under the Program, the Corporation may, at its sole discretion and to the extent it elects to do so, provide coverage supplementary to the state plan.

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SALARIED HEALTH CARE PROGRAM

Art. I, 2(b)(3)

(3) The Employee Benefit Plans Committee (EBPC) of the Corporation has final discretionary authority to construe, interpret, apply and administer the Program, and serves as the final step of the Program appeal procedure. Any interpretation or determination regarding the Program made by the EBPC shall be given full force and effect, unless it is proven that the interpretation or determination was arbitrary and capricious.

(c) Grievance Procedure Not Applicable

It is understood that the grievance procedure of any collective bargaining agreement between the Corporation and any union representing salaried employees of the Corporation shall not apply to this Program or any contract in connection therewith.

(d) Miscellaneous Information Related to the Employee Retirement Income Security Act of 1974 (ERISA)

(1) The end of the plan year is December 31. Records of the Program are kept on a calendar year basis.

(2) General Motors Corporation is the sponsoring employer and Administrator of the Program. The Administrator's address is Room 8-206, General Motors Building, Detroit, Michigan 48202.

(3) Service of legal process on General Motors Corporation may be made at any office of the CT Corporation. The CT Corporation, which maintains offices in all 50 states, is the statutory agent for service of legal process on General Motors Corporation. The procedure for making such service generally is known to practicing attorneys. Service of legal process also may be made upon General Motors Corporation, at the Service of Process Office, Room 7227, New Center One Building, Detroit, Michigan 48202.

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SALARIED HEALTH CARE PROGRAM

Art. I, 4(b)

(b) Substitution of Applicable Provisions of the Program for Coverage Under Federal Laws

Notwithstanding the provisions of subsection (a) above, the Corporation may, if Federal laws permit substitute a plan of coverage for the coverage provided by the Federal laws referred to in subsection (a) above, and modify the provisions of the Program to the extent and in the respects necessary to secure the approval of such substitution from the appropriate governmental authority and may make such plan available to enrollees.

(c) Reduction of Health Care Coverage Because of Coverage Under Federal Law

Health care benefits, separately or in combination, provided enrollees under the Program may be reduced by the amount of such coverage provided under any Federal health security act or any other Federal law which may be amended or enacted. In cases where the enrollee exercises an option under the Federal Social Security Act or similar law to take cash payments in lieu of health care coverages, the equivalent of such payments will be required as a contribution toward the health care coverages provided under the Program, but not to exceed the cost to the Corporation of such coverages. Such contributions may be deducted, in accordance with any applicable Federal laws, from any monies then payable to the enrollee in the form of salary or benefits payable under any General Motors benefit plan or program.

Section 5. Treatment of Existing Coverages on Effective Date

Protection of enrollees covered under the prior Program shall be terminated on the effective dates of the provisions of this Program, and the provisions of this Program shall be in lieu of and substitute for any and all other provisions of any prior Program providing for health care benefits of any kind or nature, in which the Corporation participates.

SALARIED HEALTH CARE PROGRAM

Art. I, 3(b)

(b) Notwithstanding the provisions of subsection (a) above, in any state which has a state-legislated plan of health coverage available to the general population including Program enrollees (or which would be available to Program enrollees but for their coverage under the Program), the Corporation may, at its sole discretion and to the extent permitted by the applicable state legislation, amend, modify, suspend, cancel or otherwise affect the provisions of the Program as they apply to enrollees in such states, in order to permit participation in such state plan in lieu of coverage under the Program.

Section 4. Federal Health Care Coverage

(a) Not Applicable to Enrollees Eligible for Such Coverage

The provisions of the Program, separately or in combination, shall not be applicable to enrollees eligible for health care coverage under any Federal health security act or any other Federal law providing such coverage which may be amended or enacted. Compliance by the Corporation with such laws shall be deemed full compliance with the provisions of the Program with respect to enrollees eligible for coverage under such laws. If such coverage exceeds the coverage provided under the Program and the Corporation's contributions for such coverage under the Program, the Corporation may require from such enrollees such contributions as it may deem appropriate for such excess coverage. If, as a result of such laws, the level of coverage provided for any group of enrollees is generally lower than the corresponding level of coverage under the Program, the Corporation may, at its option and to the extent it finds it practicable, provide a plan of coverage supplementary to the Federal coverage to the extent necessary to make total coverage as nearly comparable as practicable to the coverage provided under the Program.

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Art. I, 6

Section 6. Named Fiduciary and Appeal Procedure

(a) The Finance Committee of the Corporation's Board of Directors shall be the Named Fiduciary with respect to the Program. The Finance Committee may delegate to various officers, employees and committees of the Corporation authority to carry out such of its responsibilities as it deems proper to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended.

(b) An enrollee will be given an opportunity for a full and fair review of a decision by the Plan Administrator denying a claim for benefits or eligibility for coverage. If the enrollee believes such a decision of the Plan Administrator is inconsistent with the terms of the Program, an appeal may be filed with the Employee Benefit Plans Committee (EBPC) of the Corporation, which has been delegated final discretionary authority to construe, interpret, apply and administer the Program. Such an appeal to the EBPC must be filed in writing within 60 days from the date of the written decision from the Plan Administrator denying a claim for benefits or eligibility for coverage under the Program. Such an appeal may be initiated by forwarding the request to the Secretary, EBPC, at Room 8-263 General Motors Building, 3044 West Grand Boulevard, Detroit, Michigan 48202. As part of this review, the enrollee must submit any written comments that may support the position of the enrollee. The EBPC shall be the final review authority with respect to appeals and its decision shall be final and binding upon the Corporation and any enrollee. A written decision on the request for review will be furnished to the primary enrollee within 60 days (120 days if special circumstances require an extension of time) after the date the written request is received by the EBPC.

SALARIED HEALTH CARE PROGRAM

Art. I, 7

Section 7. Coordination of Benefits (COB)

(a) General Provisions

Health care benefits paid under this Program shall not duplicate benefits from other sources (e.g., group plans, comprehensive plans, pre-paid plans, governmental plans, etc.) nor serve to relieve other persons or organizations of their liability (contractual or otherwise). Consistent with these objectives, the Corporation may establish systems and procedures for coordination of benefits, and the carriers shall implement such systems and procedures.

(b) Applicability

(1) The provisions of this Section shall apply to all coverages provided under the Program. Unless precluded by law, these provisions apply whether the coverage is self-funded, or provided through pre-paid options such as health maintenance organizations.

(2) This Program shall not coordinate with individual or family policies of insurance purchased by the enrollee or with any group policy covering the enrollee for which the enrollee pays more than one-half the cost.

(3) The provisions of this Section shall not apply to expenses for services provided to or for an enrollee in relation to any condition, disease, illness or injury arising out of or in the course of employment, as such expenses are specifically excluded from the Program.

(4) The provisions of this Section do not apply to Medicaid. They also do not apply to Medicare or to any plan, program or policy to which Medicare is secondary by operation of law (including, without limitation, automobile insurance coverage). Medicare and such plans, programs or policies are governed by [illegible]. These COB provisions do apply to complementary plans, programs or policies other than those just described which are carried to supplement benefits available under Medicare and which are secondary to it.

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SALARIED HEALTH CARE PROGRAM

Art. I, 7(c)

(c) Enrollee Obligations

(1) Primary enrollees shall furnish to the Corporation the social security numbers of all secondary enrollees for whom they are claiming eligibility. If the secondary enrollee has not been assigned a social security number at the time of enrollment, a social security number shall be obtained promptly and reported to the Corporation. Failure to do so shall result in cancellation of coverages for such secondary enrollee.

(2) Any enrollee claiming benefits under this Program shall furnish the Corporation or the carrier(s) any information the Corporation or carrier deems necessary for the purpose of administering these provisions. Failure to do so may result in non-payment of benefits.

(d) Release of Information

(1) The Corporation or carriers may release to other employers or carriers information necessary to adjudicate claims under these provisions.

(2) The Corporation or carriers under this Program may participate in organizations which are established to facilitate the COB process and may exchange information relating to enrollees for such purposes.

Such organizations must agree not to release any information obtained other than for the purpose of effectuating COB.

(e) Determining Priority

(1) The program which, under the rules of this subsection, has the first obligation to pay benefits is termed the "primary" program, and the coverages it provides are "primary." The other program (and the coverages it provides) is termed "secondary."

(2) When the other program does not contain a COB provision, that program is always primary.

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Art. I, .7(e)(3)

(3) When the other program contains a COB provision and the order of benefit determination under each program's COB provisions establishes this Program as primary, the provisions of this Program determine this Program's liability, regardless of any payment the other program may have made.

(4) When the other program contains a COB provision, the following order of benefit determination will be used.

(i) The program covering the enrollee as an employee will be primary over the program covering the enrollee as a dependent.

(ii) When the enrollee is a dependent child whose parents are not divorced or separated, the program covering the enrollee as a dependent of the parent whose birthday occurs earlier in the calendar year will be primary over the program covering the enrollee as a dependent of the parent whose birthday occurs later in the calendar year. If the two parents' birthdays fall on the same day, the program which has covered the parent for the longer period of time will be primary.

(iii) When the enrollee is a dependent child whose parents are divorced or separated, and if there is a court order establishing financial responsibility with respect to health care expenses of the child, the program which covers the child as a dependent of the parent with such responsibility shall be primary. If there is no court order, and the parent having custody of the child has not remarried, the program covering the child as a dependent of the parent with custody shall be primary. If there is no court order and if the parent having custody has remarried, the program covering the child as a dependent of the parent having

Art. I, 7(e)(4)(iii)

custody shall be primary, any program covering the child as a dependent of the stepparent shall be secondary, and the program covering the child as a dependent of the parent without custody shall be last in responsibility for payment.

(iv) When rules (i), (ii), and (iii) above do not establish an order of benefit determination, the program which has covered the enrollee for the longer period of time will be primary.

However, if one program covers the enrollee as an active employee (or dependent of such employee) and the other covers the enrollee as a laid-off or retired employee (or dependent of such employee), the program covering the enrollee as an active employee (or dependent of such employee) shall be primary.

(f) Payment of Benefits

(1) If this Program is primary, a carrier may reimburse a secondary program for any amounts paid by such program which should have been provided by this Program.

(2) If benefits under this Program are overpaid by a carrier for any claim involving COB, the carrier shall have the right to recover such overpayment, on the Corporation's behalf, from the hospital, physician, or other provider of service, from the other program, or from the primary enrollee, as appropriate. Alternatively, the Corporation may recover on its own behalf, under Section 9 below.

(3) With regard to any claim for which this Program has secondary liability, benefits provided under this Program shall not exceed the amount of benefits payable if this Program had been primary.

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Art. I, 7(f)(4)

(4) "Benefits paid or payable" under other program include the benefits that would have been payable had a claim been made under the primary program, or which would have been payable by the primary program but for the enrollee's failure to comply with the provisions of such program. When a program provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be a benefit payable by such program.

(5) When this Program is secondary,

(i) sanctions provided under this Program (e.g., for failure to obtain predetermination, for failure to obtain a required second opinion, for failure to obtain services from a panel provider, etc.) will not apply,

(ii) payment will not exceed the amount which would have been paid by this Program had it been primary,

(iii) if the primary program's paid or payable benefits are equal to or greater than the maximum amount this Program would have paid if primary, then the Program will not pay an outstanding balance, if any; however, the enrollee will receive credit toward any deductible and/or copayment to the extent such deductible and/or copayment would have been applied if the Program had been primary,

(iv) no payment will be made for services which are not covered under this Program,

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Art. I, 7(f)(5)(v)

(v) the enrollee may be required to provide information concerning the primary program's payment or disposition prior to payment of benefits under this Program, and

(vi) if the other plan or program does not follow the same order of benefit determination rules set forth in subsection (e), above, and as a result both plans or programs take a secondary position, the Program may pay benefits not exceeding the amount it would have paid had it been the primary plan or program, but such payment shall be without prejudice to the secondary position of the Program, and the Program shall pursue recovery from the other plan or program and shall be subrogated to all rights of the enrollee against the other plan or program.

Section 8. Reimbursement for Third Party Liability

(a) If health care benefits are paid to, or on behalf of, an enrollee and if the enrollee makes recovery from a third party, individual or organization for any covered expenses for which benefits were paid, the Program shall be entitled to reimbursement in an amount equal to the benefits paid to, or on behalf of, the enrollee under this Program. Carriers administering the Program shall take such actions as may be necessary to preserve or assert such right of reimbursement on the Program's behalf.

(b) The enrollee shall provide notice to the carriers (on behalf of the Corporation) of any such recovery (or effort to recover) from a third party, and shall perform such acts and execute and deliver to the Corporation or the carrier such instruments and papers as may be necessary or helpful to secure such rights of reimbursement. These obligations include the following:

Art. I, 8(b)(1)

(1) The Corporation assumes the enrollee's gh to recover payment from any third part up to the extent of such third party's liab ity.

(2) If an enrollee recovers any monies t ough lawsuit, settlement or other means, e enrollee must reimburse the Corporat n for benefits paid.

(3) The enrollee grants the Corporation a lien on any monies the enrollee or the enrollee's beneficiaries may recover, either through settlement or otherwise, whether the recovery is designated economic or non-economic damages.

(4) The enrollee grants the Corporation the right to intervene in a lawsuit for the purpose of enforcing the Corporation's lien.

(5) The enrollee grants the Corporation the right to recover its legal fees and costs which exceed the Corporation's payment of benefits from any recovery.

(6) The enrollee agrees to inform the Corporation when the enrollee engages an attorney to pursue a claim, and to inform the enrollee's attorney of the Corporation's rights under this Program.

(7) The enrollee agrees not to settle any claim or take any action which would prejudice the Corporation's rights or interests.

Section 9. Recovery of Benefit Overpayments

If it is determined that any benefit(s) paid to, or on behalf of, an enrollee under this Program should not have been paid or should have been paid in a lesser amount, written notice thereof shall be given to the applicable primary enrollee and such primary enrollee shall repay the amount of the overpayment.

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Art. I, 9

If the primary enrollee fails to repay such amount of overpayment promptly, the Corporation shall arrange to recover the amount of such overpayment by making an appropriate deduction or deductions from any monies then payable, or which may become payable, by the Corporation or on the Corporation's behalf, or otherwise, to the primary enrollee in the form of salary, benefits or other compensation. The Corporation shall have the right, in accordance with applicable Federal laws, to make, or to arrange to have made, deductions for recovering such overpayments from any such present or future salary, benefits or other compensation which are or become payable to such primary enrollee.

Art. II

ARTICLE II
HEALTH CARE COVERAGES

Section 1. Establishment of Health Care Coverages

Only to the extent and under the terms such benefits continue to be provided under this Program, as it may be amended from time to time, the Corporation will make the following available:

(a) Core Coverages

The Corporation makes available core coverages as set forth in Appendices A, B and E.

(b) Non-Core Coverages

The Corporation makes available non-core coverages as set forth in Appendices C and D.

(c) Sub-Plans

The Corporation makes available certain sub-plans including: the International Health Care Plan (as set forth in Appendix F) and the Salaried Traditional option and Comprehensive Medical Expense Program (CMEP) for employees working in the state of Hawaii (as set forth in the provisions of the Program in effect prior to 1993).

Section 2. Uniform National Health Care Coverages

(a) The Corporation shall provide health care coverages, nationwide, as described in this Program, under a national system by agreement between the Corporation and Blue Cross and Blue Shield of Michigan, hereinafter referred to as the Control Plan, or by agreement with other carriers.

(b) The Control Plan shall have responsibility for overseeing the carriers administering the core coverages described in Appendix A for Basic Medical Plan, Enhanced Medical Plan and Preferred Provider Organization option enrollees.

Art. II, 2(c)

(c) All carriers agreeing to provide coverages under the Program, shall do so in accordance with the Program provisions, and interpretations and benefit practices established by the Control Plan, as applicable.

(d) Under the national system each carrier with a written agreement with the Control Plan will provide the core coverages described in Appendix A in the carrier's respective geographic area. If in any geographic area such a carrier fails to enter into the agreement as stated above, or fails to perform in accordance with its agreement, the Control Plan, with the approval of the Corporation, may arrange for the provision of such health care coverages in the geographic area through alternative means.

(e) Coverage may be provided through the Health Maintenance Organization option. However, the coverages provided through this option may vary from the coverages described in Appendices A and B.

Section 3. Replacement or Supplementation of Coverages

If, in its judgment, the Corporation considers it advisable, another arrangement may be substituted, in any geographic area, for all or part of the coverages referred to in Section 1 above.

Section 4. Selection of Option

The Corporation provides an opportunity for primary enrollees (other than those primary enrollees set forth in subsection (e) below) to elect coverages through the options available under the Program. Such election also may include a choice among dental options, where applicable. The specific choices offered to a primary enrollee will depend on the primary enrollee's status, the availability of approved options in the enrollee's geographic area, and the Medicare status of the primary and secondary enrollees. The medical options are as follows:

SALARIED HEALTH CARE PROGRAM

Art. II, 4(a)

(a) Preferred Provider Organization (PPO) Option

This option provides the core coverages described in Appendix A through access to a panel of providers who have agreed to provide services under the terms of participation established by the preferred provider organization such as limits on fees and controls on quality and utilization. Mental health and substance abuse care for enrollees of this option are provided under Appendix B. Extended Care Coverage, under Appendix E, is available to enrollees of this option. Core coverages (other than certain screening tests/examinations and prescription drug coverage, as set forth in Appendix A and those core coverages under other appendices) are subject to a 10% copayment applicable to covered expenses, up to a calendar year maximum out-of-pocket cost of $1,300 for an individual and $2,600 for a family. In order to receive maximum benefits for covered services, such services must be obtained through the organization's panel of providers.

(1) A preferred provider organization assumes responsibility for conducting utilization reviews, predetermination of services, or other reviews necessary to promote quality of care and control costs. A preferred provider organization may place the panel physician and other providers at financial risk through capitation, withholding of a percentage of fees, or other mechanisms, or if not, will have other means to monitor and control utilization by individual providers on a continuous basis.

(2) A preferred provider organization assumes responsibility for selection and periodic evaluation of hospitals, physicians, laboratories, and other providers to ensure sufficient numbers and types of providers who are geographically distributed to allow adequate access for enrollees.

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Art. II, 4(a)(3)

(3) A preferred provider organization assumes responsibility for providing the scope and level of benefits set forth in Appendix A, monitoring the appropriateness of referrals to non-panel providers, taking affirmative corrective action with respect to providers when necessary, and implementing and maintaining other administrative processes as required by the Corporation.

(4) Maximum benefits are available only if the services are rendered by panel providers, or by non-panel providers if such services are on referral from a preferred provider organization panel physician, subject to the conditions below.

(i) The referring panel physician is responsible for communicating the referral to the carrier and monitoring the progress of the patient. Any subsequent referrals must be made by a panel physician.

(ii) The carrier is responsible for monitoring referral frequency and patterns, and for ensuring that additional costs are not incurred by the Program or the enrollee.

(iii) A service which would not otherwise be a covered service does not become a covered service by virtue of a referral.

(iv) Payment for a covered service provided by a non-panel provider, unless the enrollee is referred by a panel provider or in an emergency (as determined by the carrier), will be 70% of the preferred provider organization's level of payment for the same service or, if less, 70% of the actual charge. The enrollee will be responsible for the difference between the preferred provider organization's payment and the non-panel provider's charge. The amount of the enrollee's liability will not be applied to the $1,300 individual or $2,600 family out-of-pocket maximum.

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Art. II, 4(a)(5)

(5) Preferred provider organizations may se
Corporation approval to establish speci
contractual relationships with provide ac
otherwise included under the Program w i can
be shown that doing so will improve qu ity f
care and enhance cost competitiveness

(b) Health Maintenance Organization (HMO) Opt n

This option provides core coverages (other than Extended Care Coverage) to enrollees through physicians, hospitals, and other providers who have agreed to provide services under the terms established by the health maintenance organization to limit fees, assure quality, and control utilization. Extended Care Coverage, under Appendix E, is available to enrollees of this option.

(1) The types of coverages and the scope and level of coverages provided under this option may vary among health maintenance organizations and may be different than the coverages set forth in Appendices A and B.

(2) Most health maintenance organizations provide health care coverages (including preventive care) that generally are managed for the enrollee by a primary care physician. The primary care physician is responsible for referring the patient to other providers of service. If such referral is not obtained, the enrollee may be responsible for charges incurred.

(3) Under this option, if an enrollee receives services from a non-health maintenance organization provider, in a non-emergency situation or without a referral, such services may not be covered.

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Art. II, 4(c)

(c) Basic Medical Plan (BMP) Option

This option provides the core coverages described in Appendix A. Mental health and substance abuse care for enrollees of this option are provided under Appendix B. Extended Care Coverage, under Appendix E, is available to enrollees of this option. Core coverages (other than certain screening tests/examinations and prescription drug coverage as set forth in Appendix A and those core coverages under other appendices) are subject to a $900 individual and $1,800 family calendar year deductible. No more than $900 for an individual may be counted toward satisfying the family deductible, but the family deductible may be met without any individual meeting the individual deductible amount. After the deductible is satisfied, a 25% copayment is required for covered expenses (other than those exempted from the deductible above), up to a combined calendar year maximum out-of-pocket expense for deductibles and copayments of $2,500 for an individual and $5,000 for a family. This option contains predetermination and review procedures required in order to receive maximum benefits for certain covered services. These procedures include, but are not limited to, predetermination (which includes, but is not limited to, prior authorization or assessment for non-emergency inpatient admissions), concurrent utilization review, retrospective utilization review, and focused utilization review. In some instances, special programs (such as foot surgery predetermination, predetermination of specific outpatient procedures or second opinions for selected procedures) will be developed and implemented, as necessary and practicable, to address specific utilization problems.

(1) Benefits for certain covered services, which require predetermination, when provided without obtaining necessary predetermination approvals will be administered according to Program standards including the provision that reimbursement be limited to 80% of reasonable and

Art. II, 4(c)(1)

customary charges after the first $100 of expense for such services. The reimbursement to providers will be reduced to reflect any waiver or forgiveness by a provider of the $100 o remaining 20%. Any liability incurred by an enro lee for failure to comply with the predetermi cion requirement is in addition to the ded ctible and copayment amounts (which shall be det ermined after applying this provision).

(2) The predetermination sanctions referred to in subsection (1) above shall not be applicable (i) to an individual enrollee who has incurred a personal expense of $750 for sanctions under this provision for such covered services in a calendar year or (ii) to the covered members of the enrollee's family, if any, after the enrollee and such members have incurred a total of $1,500 in personal expense for sanctions under this provision for such covered services in the same calendar year.

(3) Primary and secondary enrollees eligible for Medicare and enrolled in the Basic Medical Plan option may not be subject to the predetermination and review procedures set forth above for those covered services for which Medicare has primary responsibility.

(d) Enhanced Medical Plan (EMP) Option

This option provides the core coverages described in Appendix A. Mental health and substance abuse care for enrollees of this option are provided under Appendix B. Extended Care Coverage, under Appendix E, is available to enrollees of this option. Core coverages (other than certain screening tests/examinations and prescription drug coverage as set forth in Appendix A and those core coverages under other appendices) are subject to a $300 individual and $600 family calendar year deductible. No more than $300 for an individual may be counted toward satisfying the family deductible, but the family deductible may be met without any individual meeting the individual deductible amount. After the deductible has been satisfied, a 20% copayment will be required for covered expenses (other than those exempted from the deductible above), up to

SALARIED HEALTH CARE PROGRAM

Art. II, 4(d)

a calendar year maximum combined out-of-pocket cost for deductibles and copayments of $1,300 for an individual and $2,600 for a family. This option contains predetermination and review procedures required in order to receive maximum benefits for certain covered services. These procedures include, but are not limited to, predetermination (which includes, but is not limited to, prior authorization or assessment for non-emergency inpatient admissions), concurrent utilization review, retrospective utilization review, and focused utilization review. In some instances, special programs (such as foot surgery predetermination, predetermination of specific outpatient procedures or second opinions for selected procedures) will be developed and implemented, as necessary and practicable, to address specific utilization problems.

(1) Benefits for certain covered services, which require predetermination, when provided without obtaining necessary predetermination approvals will be administered according to Program standards including the provision that reimbursement be limited to 80% of reasonable and customary charges after the first $100 of expense for such services. The reimbursement to providers will be reduced to reflect any waiver or forgiveness by a provider of the $100 or remaining 20%. Any liability incurred by an enrollee for failure to comply with the predetermination requirement is in addition to the deductible and copayment amounts (which shall be determined after applying this provision).

(2) The predetermination sanctions referred to in subsection (1) above shall not be applicable (i) to an individual enrollee who has incurred a personal expense of $750 for sanctions under this provision for such covered services in a calendar year or (ii) to the covered members of the enrollee's family, if any, after the enrollee and such members have incurred a total of $1,500 in personal expenses for sanctions under this provision for such covered services in the same calendar year.

SALARIED HEALTH CARE PROGRAM

Art. II, 4(d)(3)

(3) Primary and secondary enrollees eligible for Medicare and enrolled in the Enhanced Medical Plan option may not be subject to the pre ermination and review procedures set forth abov for those covered services for which Medicare as primary responsibility.

(e) Options Available to International Service Personnel, Flexible Service Employees, Cooperative Students and Employees Working in Hawaii

Unless otherwise noted, employees classified as International Service Personnel, Flexible Service Employees, or Cooperative Students and employees working in Hawaii are not eligible to elect the medical care options described in subsections (a), (b), (c), and (d) above. Coverages for such employees are described below:

(1) International Service Personnel

Except for employees assigned to Canada and continuing to reside in the United States (who are limited to the coverages and options applicable to salaried employees of United States operations who reside in the United States), employees classified as International Service Personnel are eligible for the coverage provided under the International Health Care Plan as described in Appendix F. Extended Care Coverage is not available. Coverage under the Comprehensive Medical Expense Program of the Program which was in effect prior to January 1, 1993 is available, provided the enrollee makes the required monthly contributions.

(2) Flexible Service Employees

Employees classified as Flexible Service Employees are only eligible for the core coverages under the Basic Medical Plan as set forth in subsection (c) above and in Appendices A and B, and for non-core coverages as set forth in Appendices C (except alternative dental plans) and D. They have no other coverage options. Flexible Service Employees are not eligible for Extended Care Coverage.

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Art. II, 4(e)(3)

(3) Cooperative Students

Employees classified as Cooperative Students are only eligible for the core coverages under the Basic Medical Plan as set forth in subsection (c) above and in Appendices A and B. They have no other core coverage option. Cooperative Students are not eligible for dental or vision coverage and are not eligible for Extended Care Coverage.

(4) Employees Working in Hawaii

Employees working in Hawaii are eligible only for the following coverages as set forth under the Program in effect prior to January 1, 1993: Appendix A Traditional option coverage; Appendix B mental health and substance abuse coverage; and Appendices C and D dental and vision coverages. These coverages have been and may be modified from time to time. Such employees also are required to participate in the Comprehensive Medical Expense Program coverage of the Program in effect prior to January 1, 1993 (on a contributory basis), unless they waive medical coverage in accordance with state law.

ARTICLE III
ENROLLMENT, ELIGIBILITY, COMMENCEMENT, CONTRIBUTIONS AND CONTINUATION

Section 1. Enrollment

(a) An eligible primary enrollee must complete an application for the coverages in which the enrollee elects to participate. The application or enrollment form shall include an authorization for payroll or retirement check deductions for contributions which may be required. A primary enrollee not making an election, completing an application or authorizing deductions (enrollee contributions) may be assigned to an option by the Corporation or may have coverage suspended pending such election, application or authorization.

(1) At the primary enrollee's option such coverage may include the following enrollment classifications: (i) self only, (ii) self and spouse, (iii) self and child (children), or (iv) self and family. Family coverage shall include only spouse and eligible children as defined in Section 9 of this Article.

(2) Primary enrollees who are employees eligible for all coverages under the Program and to participate in the Flexible Benefits Program may elect (i) core coverages alone, (ii) core coverages plus any or all non-core coverages, (iii) any or all non-core coverages without core coverages, (iv) to "opt out" of some or all coverages and have "benefit dollars" applied to other benefits or (v) to waive all coverages to be enrolled as a dependent of another primary enrollee. Those who opt out of or to waive coverage may be subject to restrictions on reenrollment.

(3) Primary enrollees who are retirees or surviving spouses may elect (i) core coverages alone, (ii) core coverages plus any or all non-core coverages, (iii) any or all non-core coverages without core coverages, (iv) to waive coverage to be covered as

a dependent of another primary enrollee or (v) reject coverages. Waiving or rejecting coverage may result in restrictions on reenrollment. Retirees and surviving spouses must elect Medical Plan coverage in order to have Extended Care Coverage, but may decline Extended Care Coverage while retaining Medical Plan coverage. However, if they do so, they may be ineligible to participate in it at a later date. Also, retirees and surviving spouses who are eligible to continue participation in the Program only on a self-paid basis will not be permitted to enroll/reenroll if they do not elect to enroll when first eligible or initially enroll but have coverage discontinued for failure to make the required contributions.

(4) The primary enrollee's election shall apply to all dependents.

(5) When a husband and wife both qualify as primary enrollees, each may make a separate election. However, no individual may have coverage as both a primary and a secondary enrollee, nor as a secondary enrollee under more than one primary enrollee.

(6) If a primary enrollee's coverage otherwise available under this Program is waived or canceled, and based upon such waiver or cancellation the primary enrollee receives some financial consideration from the Corporation (under this or any other Corporation plan or program), such primary enrollee shall be precluded from coverage as a secondary enrollee under another person's coverage, for a period of time equal to that upon which such consideration is based. This provision also applies to secondary enrollees, if any, included in the waiver or cancellation on which such consideration is based.

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Art. III, 1(a)(7)

(7) At their option, retired employees or surviving spouses who are enrolled for health care coverages as provided in the program, and who have permanently changed the residence from the service area of the carrier with which they are enrolled for such coverages may transfer their coverages to a local carrier serving the area in which they reside.

Such transfers shall become effective the first day of the month following the receipt of the application for transfer. Two transfers shall be allowed in any calendar year.

(8) The Corporation may continue to make arrangements for employees and retirees of locations in the United States (including eligible surviving spouses of such former employees) who live in Canada and are eligible for Corporation contributions for health care, to elect on an optional basis to participate in the hospital, surgical, medical, prescription drug, hearing aid, dental, vision, Comprehensive Medical Expense Insurance Program, mental health and substance abuse coverages, and/or other coverages as may be provided for eligible employees of General Motors Canadian operations.

The Canadian coverages, if elected, will be in lieu of coverages available at the location where employed or from which retired. Such election shall remain in effect while the primary enrollee remains a resident of Canada.

(b) The primary enrollee may be required to make monthly contributions as set forth in the Program, according to the primary enrollee's status, the enrollment classification, the option elected, the Medicare status of enrollees, and the type and number of dependents enrolled.

SALARIED HEALTH CARE PROGRAM

Art. III, 2

Section 2. Dates of Eligibility, Commencement of Coverages, and Corporation Contributions for Active Employees

(a) Eligibility and Commencement of Coverages for Current and New Employees

An employee shall become eligible for all Program coverages on January 1, 1994 or, if later, on the first day of the third month following the month of hire, provided the employee is in active service on the first working day of such month. Salaried employees working in Hawaii become eligible the first day of the month following the month of hire. United States salaried employees hired directly to International Service Personnel positions (ISP-U.S.) are eligible for coverage upon date of hire. If an employee is not in active service on the date coverages otherwise would start, coverages will become effective upon the employee's return to work.

(b) Eligibility and Commencement of Coverages for Employees Returning to Active Work

If an employee's coverages are discontinued and the employee subsequently returns to active work, eligibility for coverages shall be determined in subsection (a) above, except as provided in subsections (1) through (4) below.

(1) Returning From Layoff or Leave of Absence

If an employee's coverages were discontinued while on layoff or leave of absence and the employee returns to active work with unbroken length of service, the employee shall be eligible for health care coverages immediately on the date of return to active work with the Corporation.

(2) Returning From Separation From Service Due to a Quit or Discharge

If separation from service was due to a quit or discharge but the employee is reemployed within

31 days, the employee shall be eligible fo.. health care coverages immediately on the · te of return to active work.

(3) Returning From Separation From Service f · Reason Other Than Quit or Discharge

If separation from service was due to a reason other than quit or discharge and the employee had health care coverages in effect before breaking length of service, and if the employee returns to active work within a period of 24 consecutive months, the employee shall be eligible for health care coverages immediately on the date of return to active work with the Corporation.

(4) Returning From Military Leaves of Absence

An employee reporting for work from military leave of absence in accordance with the terms of such leave shall be eligible for health care coverages as of the date the employee reports available for work.

(5) Transferring To/From Regular Active Service From/To International Service Personnel, Cooperative Student or Flexible Service Status

If an employee transfers to/from regular full-time status from/to International Service Personnel, Cooperative Student or Flexible Service status, the employee shall be eligible for health care coverages, based on the new status, effective with the first day of the month following the change of status, unless the change of status is on the first day of the month in which case the change of coverage is effective that day.

SALARIED HEALTH CARE PROGRAM

Art. III, 2(c)

(c) Corporation Contributions for Employees in Active Service

(1) With respect to any month in which the employee is in active service with the Corporation and eligible for coverage as specified in this Section 2 as of the beginning of the month, the Corporation shall make contributions for that month's coverages as specified in the Program.

(2) With respect to any month in which an employee does not meet the requirements of subsection 2(c)(1) above by virtue of not being in active service at the beginning of the month, but in which an employee returns to work and is eligible for reinstatement of coverages under subsection 2(b) above, the Corporation shall make contributions as specified in the Program effective with the date of return to work.

Section 3. Continuation of Coverages During Layoff

(a) Health care coverages will be provided until the end of the month in which the employee is last in active service.

(b) Dental coverages shall not be continued during periods of layoff beyond the end of the month in which the employee is last in active service.

(c) As set forth in subsections (d), (e) and (f) below, core and vision coverages shall be continued during periods of layoff for up to 25 consecutive months (except as provided in the following paragraph) following the last month of coverage for which the Corporation contributed for the employee in accordance with subsection (a) above, provided the employee's length of service is not broken.

Notwithstanding any other provisions of this Section 3, if an employee is on layoff and returns to active work with the Corporation as a Regular Employee-Temporary Assignment (RETA) and subsequently returns to layoff status, the number of months for which coverage may be continued as of the first day of the month next

SALARIED HEALTH CARE PROGRAM

Art. III, 3(c)

following the month in which the employee last orks, and the number of months for which the Corpora on shall contrib for any such continued covera , shall be equa to the number of such months, respectively, which were available as of the ast day of the month immediately preceding the date of return to work with the Corporation.

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Art. III, 3(d)

(d) The Corporation has established a schedule, set forth in subsection (e) below, on the basis of length of service as of the date of layoff, under which the Corporation will contribute, during a specified number of full calendar months of layoff, for core and vision coverages continued in accordance with subsection (c) above.

(e) Schedule of Continuance of Core and Vision Coverages for Employees on Layoff

Length of Service (months)	# of Months of Full Corporation Contribution	Maximum Months of Coverage Self-Paid 50%
4	-	4
5	-	5
6	-	6
7	-	7
8	-	8
9	-	9
10	-	10
11	-	11
12	12	0
13, but less than 120	13	0
120 or more	25	0

(f) Employees with less than 12 months length of service as of the date of layoff shall pay 50% of the full cost to continue coverages in accordance with the Schedule shown in (e) above. The maximum duration of continuation in the Program is as shown.

(g) Employees eligible for Income Protection Plan (IPP) benefits may be eligible for certain health care coverages as determined by that program.

(h) Employees Placed On Layoff From Disability Leave of Absence

For an employee at work on or after March 1, 1982 who, upon reporting for work from an approved disability leave of absence, is immediately placed on layoff, the day the employee reports for work shall be deemed to be the last day in active service prior to layoff for purposes of this Section. The coverages to be continued during such layoff will be those for which the employee was covered on the actual day last worked.

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Art. III, 3(i)

(i) Employees Placed On Layoff From Military Leave of Absence

If an employee reports for work from military leave of absence in accordance with the terms of such leave and is immediately placed on layoff, the day the employee reports for work shall be deemed to be the last day worked prior to layoff but only for purposes of determining the period of continuation and eligibility for Corporation contributions for such coverages under the provisions of the Program applicable to laid-off employees.

Section 4. Continuation of Coverages During Disability Leave of Absence

(a) Health care coverages (other than dental for an approved disability leave of absence commencing prior to September 17, 1979) shall be continued for the duration of an approved disability leave of absence provided the employee is totally and continuously disabled and makes any required monthly contributions.

(b) If an employee's disability leave is canceled because the period of such leave equaled the length of the employee's service, coverages continued while on disability leave, in accordance with subsection (a) above, shall continue to remain in force in any month in which the employee continues to receive salary continuation, Sickness and Accident Benefits or Extended Disability Benefits in accordance with the General Motors Life and Disability Benefits Program for Salaried Employees subsequent to such cancellation. This provision is contingent upon the employee making any required monthly contribution.

(c) The Corporation shall make contributions, in accordance with Program provisions, for health care coverages continued in accordance with subsections (a) and (b) above.

SALARIED HEALTH CARE PROGRAM

Art. III, 5

Section 5. Continuation of Coverages During Other Leaves of Absence

(a) Employees on leave of absence under the Family and Medical Leave Act of 1993 shall have coverages continued in accordance with that Act. Health care coverages for an employee on any other type of approved non-disability leave of absence shall be continued to the end of the month in which the employee is last in active service.

(b) An employee who desires to continue coverages (other than dental) beyond the period specified in subsection (a) above may do so, provided the employee contributes for coverage as described in (1), (2) and (3) below.

(1) Interim Special Leave. Coverage may be continued for up to 24 months provided the employee pays 50% of the full monthly cost for the first 12 months and 100% of the full monthly cost thereafter.

(2) Educational Leave. Coverage may be continued for the duration of such leave provided the employee pays 50% of the full monthly cost.

(3) Coverage for all other non-disability leaves may be continued for up to 12 months provided the employee pays 50% of the full monthly cost.

(c) From time to time, the Corporation may establish certain leave programs under which employees may be offered limited continuation privileges provided they make specified monthly contributions. Such programs may vary in percentage of the full cost of coverage which the employee is required to pay and in the length of the continuation period as stipulated by the leave program.

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Art. III, 5(d)

(d) If an employee has not broken service and has con inued coverages as provided in subsection (b) above du- ng an approved leave of absence other than for disabil y, granted because of a clinically anticipated dis- ility based on the natural course of the employee's · agnosed condition, and presents medical certification om the employee's personal physician, satisfactory t he Corporation, that the employee is totally di ed, health care coverages shall be provided, as o- the date such certification is presented, on the same basis as set forth in Section 4.

(e) The Corporation shall make contributions for health care coverages continued in accordance with subsection (d) above, on the same basis as set forth in Section 4, as of the date certification of disability is presented.

Section 6. Continuation of Coverages Upon Retirement or Termination of Employment at Age 65 or Older

(a) An employee who retires under the General Motors Retirement Program for Salaried Employees (other than a deferred vested retirement) or terminates employment at age 65 or older (for any reason other than a discharge for cause) may continue health care coverages.

(b) An employee who upon retirement is not enrolled for the coverages as provided in subsection (a) above may enroll for health care coverages to which entitled at the time of or subsequent to retirement. Such coverage shall become effective on the first of the month following receipt of application from such retired employee.

(c) The Corporation shall make contributions, in accordance with Program provisions, for health care coverages continued in accordance with subsections (a) and (b) above, except for:

(1) an employee who retires voluntarily at or after age 55 and prior to age 60, when age and credited service total less than 85;

(2) an employee age 60 or older, but less than age 65, who retires prior to February 1, 1989 without being eligible for retirement benefits;

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Art. III, 6(c)(3)

(3) an employee who retires on or after February 1, 1989 with less than ten years of credited service under the General Motors Retirement Program for Salaried Employees; or

(4) an employee whose continuous service with the Corporation commences on or after January 1, 1993 and who retires after that date.

Individuals specified in (1), (2), (3) and (4) above must pay the full cost in order to continue coverages. If they decline to continue, or discontinue making the required contributions, they will not be eligible to reenroll.

Section 7. Continuation of Coverages Upon Termination of Employment Other Than by Retirement or Death

Except as provided in subsection (b) of this Section 7, when an employee quits or is discharged, any health care coverages in effect shall cease automatically as of the last day of the month in which the employee quits or is discharged.

(a) Following termination of employment other than by retirement or death, the former employee shall be entitled to continuation of coverages provided under applicable Federal laws (see Section 11, below), or to obtain a conversion contract (see Section 10, below).

(b) From time to time the Corporation may establish certain separation programs under which employees separating may be offered limited health care coverage continuation privileges. In such cases, acceptance of Program continuation under the separation program shall be an alternative to self-paid continuation under applicable Federal laws. Employees separating under such programs must choose between Program continuation and self-paid continuation.

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Art. III, 8

Section 8. Continuation of Coverages for the Survivors of Employees, of Retired Employees or of Certain Former Employees

(a) General Provisions

(1) If a primary enrollee dies after coverages are in effect under the Program, coverage for any enrolled dependents (including sponsored dependents) will cease at the end of the month in which the primary enrollee dies. Thereafter, a surviving spouse may be eligible to enroll in and/or continue coverages as provided in subsections (b) through (h), below.

(2) When an employee or retiree dies and leaves no surviving spouse eligible for coverages under this Section 8, any remaining enrolled dependents (including a spouse who is ineligible for surviving spouse coverage under this Section 8 due to having been married to the deceased employee for less than the one full year immediately preceding the date of death) whose coverage terminates at the end of the month in which the employee or retiree dies, may be eligible to continue coverages, on a self-paid basis, under applicable Federal laws (see Section 11, below) or to obtain a conversion contract (see Section 10, below).

(3) For purposes of this Section 8, "surviving spouse" does not include a former employee's spouse who is eligible only for a deferred retirement benefit under the General Motors Retirement Program for Salaried Employees; a spouse or former spouse who is receiving, or eligible to receive, a pre-retirement survivor benefit under the above referenced retirement program; or a spouse who is enrolled as a sponsored dependent.

(4) Coverage which may be available under this Section 8 to a surviving spouse is available as an alternative to the continuation privilege which may be provided under Federal law (see Section 11, below). The surviving spouse must make an election no later than 60 days following the later of the end of the month in which the death of the employee

or retiree occurs or the date of notice of available options by the Corporation. A surviving spouse who is ineligible for Corporation contributions and who fails to make a timely election as indicated above will not be permitted to enroll for coverage at a later date.

(5) Except as provided in Article III, Section 9(c)(2), below, a surviving spouse continuing coverage under this Section 8 may not add dependents to the coverage. Coverage may be continued for dependent children and sponsored dependents enrolled as of the decedent's date of death, subject to their continued satisfaction of Program eligibility criteria.

(6) A surviving spouse age 65 or older and eligible to enroll for coverage under Medicare Part B must enroll, and maintain enrollment, in Medicare Part B in order to be eligible for Corporation contributions for coverage under this Program. If not enrolled in Medicare Part B, such surviving spouse must pay the full cost to continue Program coverage. If the surviving spouse fails to make the payments necessary to continue coverage, and as a result coverage is not activated or is canceled, eligibility for coverage under the Program may cease. However, if the surviving spouse remains eligible, coverage will not be reinstated unless/until the surviving spouse demonstrates enrollment in Medicare Part B.

(7) When a surviving spouse is required to make contributions to continue coverages, the contributions shall be paid directly to the Corporation or its agent on or before the first day of the month for which such coverages are to be provided, or such other due date as may be established by the Corporation. Failure to make the required monthly contributions by the end of the month for which coverage is to be provided will result in cancellation of coverage.

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Art. III, 8(a)(8)

(8) Once coverage is rejected, or canceled [illegible] failure to make required contributions [illegible] may only be reinstated if the surviving sp[illegible]e was continuously eligible for coverage but [illegible]ot enrolled under the Program pending enr[illegible]llment in Medicare Part B [see subsection (6), above] or not enrolled as a surviving spouse due to being enrolled as a primary or secondary en[illegible]ollee under other provisions of the Program.

(b) Employees and Retirees Whose Deaths Occur Prior to November 1, 1993

The continuation period of a surviving spouse whose coverage as such commenced prior to November 1, 1993 shall be in accordance with the provisions of the Program applicable as of the date of the employee's or retiree's death.

(c) Employees Whose Deaths Occur Prior to Becoming Eligible for Coverage Under the Program

(1) If the surviving spouse was married to the deceased employee for at least the one full year immediately preceding the date of death, and the employee dies prior to becoming eligible for coverages under the Program, the Corporation will permit the surviving spouse to enroll for core coverages on a self-paid basis.

(2) If such surviving spouse elects to enroll for coverage in accordance with subsection (c)(1) above, coverage may be continued for at least 24 months. If, as of the employee's date of death, the surviving spouse's age is at least 45 or the surviving spouse's age when added to the deceased employee's years of credited service totals 55 or more, coverage may be continued beyond the 24 months, to the earliest of t[illegible]e surviving spouse's remarriage, attainment [illegible] age 62 or death.

SALARIED HEALTH CARE PROGRAM

Art. III, 8(d)

(d) Employees Whose Deaths Occur After Becoming Eligible for Coverage But Prior to Attaining Ten Years of Credited Service

(1) If the surviving spouse was married to the deceased employee for at least the one full year immediately preceding the date of death, and the employee dies after becoming eligible for coverage but prior to attaining ten years of credited service, the Corporation will make contributions to continue core coverages for 12 months. Thereafter, the surviving spouse may continue coverages for at least an additional 12 months, on a self-paid basis.

(2) If, as of the employee's date of death, the surviving spouse's age is at least 45 or the surviving spouse's age when added to the employee's years of credited service totals 55 or more, the self-paid coverage may be continued beyond the period specified in subsection (1) above, to the earliest of the surviving spouse's remarriage, attainment of age 62 or death.

(e) Employees Whose Deaths Occur After Attaining Ten or More Years of Credited Service But Prior to Being Eligible to Retire Voluntarily

(1) If an employee dies after becoming eligible for health care coverage and after attaining ten years of credited service but prior to becoming eligible to retire voluntarily under the Corpora ion's salaried policies and procedures, and if the surviving spouse is receiving a Part B survivor benefit under the General Motors Retirement Program for Salaried Employees, the Corporation shall make contributions for the surviving spouse to continue core and non-core coverages

(i) until the later of 24 months, the surviving spouse's remarriage or the surviving spouse's death, if the deceased employee was hired prior to January 1, 1993, or

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Art. III, 8(e)(1)(ii)

(ii) for 12 months, if the employee was hired on or after January 1, 1993. Following this 12-month period the surviving spouse may continue coverages on a self-paid basis for an additional 12 months, and thereafter until remarriage.

(2) If the deceased employee meets the criteria of this subsection (e) but the surviving spouse is not eligible for a Part B survivor benefit under the referenced Retirement Program, the surviving spouse will be eligible to continue coverages as in subsection (d), above.

(f) Employees Whose Deaths Occur After Becoming Eligible to Retire Voluntarily

(1) If an employee dies after becoming eligible to retire voluntarily under the Corporation's salaried policies and procedures, the Corporation shall make contributions for the surviving spouse to continue core and non-core coverages until the death of the surviving spouse, provided

(i) the employee was hired prior to January 1, 1988 and has 30 or more years of credited service as of the date of death,

(ii) the employee has at least ten years of credited service and the employee's age when added to the employee's years of credited service as of the date of death total 85 or more, or

(iii) the employee has at least ten years of credited service and is age 60 or older as of the date of death and the surviving spouse is receiving a Part B survivor benefit under the Salaried Retirement Program.

(2) If the employee was hired prior to January 1, 1993 but does not meet the criteria of subsections (1)(i), (ii), or (iii) above, or if the employee was hired on or after January 1, 1993, the Corporation shall make contributions

for the surviving spouse to continue core and non-core coverages for 12 months. Thereafter, the surviving spouse may continue coverage on a self-paid basis.

(g) Employees Whose Loss of Life Results From Employment With General Motors Corporation

(1) If an employee's loss of life results from accidental bodily injuries caused solely by employment with General Motors Corporation, and results solely from an accident in which the cause and result are unexpected and definite as to time and place, the Corporation will make contributions for the surviving spouse to enroll in and/or continue core and non-core coverages until remarriage.

(2) If such surviving spouse remarries and would have been eligible to continue coverages for a longer period under any subsection above, coverages may be continued in accordance with the appropriate subsection, with coverages and Corporation contributions continued under this subsection counted toward the maximum continuation periods specified in the applicable subsection.

(h) Retirees

(1) If the surviving spouse is eligible only for sponsored dependent coverage as of the retiree's date of death, and is not enrolled as such, no coverage is available. If enrolled as a sponsored dependent, only conversion is available (see Section 10, below).

(2) If the retiree's coverage in retirement is self-paid, and the surviving spouse is enrolled or eligible to be enrolled as a spouse, the surviving spouse may enroll in and/or continue core and non-core coverages on a self-paid basis until death. The election and required payments must be made in a timely manner [see subsection (a), above].

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Art. III, 8(h)(3)

(3) If the retiree is receiving or entitled to receive Corporation contributions for cove ge in retirement and if the surviving spouse enrolled or eligible to be enrolled as the retiree's spouse as of the date of death, he surviving spouse is eligible for Corpora on contributions for core and non-core cov ges until death.

Section 9. Dependent Eligibility Provisions

(a) General Provisions

(1) As used in this Section 9, when reference is made to a person (i.e. - person A) being "dependent upon" another person (i.e. - person B), the term shall mean that person B may legally claim, and does claim, an exemption for person A, under Section 151 of the Internal Revenue Code, for Federal income tax purposes.

(2) The provisions of this Section 9 apply with respect to enrollment of certain dependents as secondary enrollees under primary enrollees who elect "self and spouse," "self and child (children)," or "self and family" enrollment, in accordance with Article III, Section 1(a)(1) of the Program and to enrollment of sponsored dependents under subsection (d) below. Unless specifically provided otherwise in the Program, such a dependent has no individual or personal right of enrollment, right to select an option within the Program, or right to continue coverages under the Program.

(3) The Corporation shall have the sole right of determining eligibility of a dependen , consistent with the provisions of this Program.

(4) A primary enrollee claiming initial c ontinuing eligibility of a dependent shall be re. nsible for informing the Corporation of any ch. ge in status of the dependent which may affec eligibility for coverage under the Prog: . The

primary enrollee shall furnish whatever documentation the Corporation requests or which may be necessary to substantiate the claimed eligibility of a dependent and the social security number of each dependent who is eligible for one. Refusal or failure to furnish such documentation when requested to do so, or to furnish the social security number within a reasonable period of time, shall result in denial or withdrawal of eligibility for such dependent.

(5) Unless otherwise provided, a dependent who loses eligibility in accordance with the provisions of this Program, and who once again meets the requirements for dependent eligibility, may have coverage reinstated.

The effective date of coverage in such cases will be the first day of the month following the month in which a valid enrollment form and any necessary or requested supporting documentation is received by the Corporation.

(6) When, as a result of oversight or error, an eligible primary or secondary enrollee entitled to coverage is not enrolled in a timely manner, coverage may be provided retroactive to the date of eligibility that would have been established if proper processing had occurred. However, the retroactivity will not exceed 12 months from the month in which the error or omission is discovered, unless the error or omission is on the part of the Corporation.

This retroactive enrollment provision shall not apply to surviving spouses who are not entitled to Corporation contributions for coverage. Such surviving spouses electing to continue coverages on a self-paid basis must make such election as stipulated in Article III, Section 8 (a). This retroactive enrollment provision also shall not apply to sponsored dependents, as discussed in subsection (d) below.

SALARIED HEALTH CARE PROGRAM

Art. III, 9(a)(7)

(7) The receipt of a benefit under the General Motors Retirement Program for Salaried Employees as an "alternate payee" in accordance with the Retirement Equity Act of 1984 shall not serve to entitle such recipient to coverages or continuation of coverages under this Program.

(8) Any dependent, including a spouse, acquired by a retiree on or after July 1, 1988, will be limited to coverage as a sponsored dependent as set forth in subsection (d) below. A dependent is not "acquired" after retirement if the dependent's relationship with the primary enrollee was established prior to the primary enrollee's retirement and has existed continuously thereafter.

(9) Provisions will be made for the enrollment and administration of coverage for an individual determined to qualify for coverage pursuant to a Qualified Medical Child Support Order (QMCSO) under the provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93).

(b) Spouse

(1) The spouse of an eligible and enrolled employee or retiree shall be eligible for coverage except as stated in subsection (a)(8) above. A surviving spouse of an employee or retiree, as defined in Section 8 above, may not have or add a new spouse as a dependent.

(2) A spouse by common-law marriage shall be eligible for coverage only to the extent such relationship is recognized by the laws of the state in which the employee or retiree is enrolled, and the employee or retiree has met such requirements for documentation of the status as may be necessary by law and required by the Corporation.

(3) The effective date of coverage for a spouse shall be the later of the effective date of coverage for the employee or retiree, or the date of marriage. For a common-law spouse, the effective date of coverage shall be the date of receipt by the Corporation of a completed enrollment form and any necessary or requested supporting documentation.

SALARIED HEALTH CARE PROGRAM

Art. III, 9(b)(4)

(4) A spouse's eligibility for coverage shall cease on the earlier of:

(i) the date the primary enrollee's coverage ceases, except that, in the case of the primary enrollee's death, coverage shall cease on the last day of the month in which the primary enrollee dies, unless the spouse is eligible for coverage as a surviving spouse as set forth in Section 8 of this Article, or

(ii) the date of the final decree of divorce.

(c) Children

(1) Children of a primary enrollee, or of the spouse of an eligible and enrolled employee or retiree, shall be eligible for coverage if, as to each child, all of the following criteria are met.

(i) Relationship. The child must be the child of the primary enrollee, or of an employee's or retiree's spouse, by birth or legal adoption.

This requirement will be deemed to have been met for a child who was properly enrolled under the then applicable Program's "guardianship" or "principally supported child" provisions as of October 31, 1992, who has continued to be the primary enrollee's dependent since that time, and who has continuously satisfied the other eligibility criteria for children.

A child in the process of being adopted by a primary enrollee will be deemed to satisfy the relationship test when the primary enrollee takes physical custody of the child pursuant to the adoption procedure and the child resides with the primary enrollee, or on an earlier date if required under OBRA '93.

SALARIED HEALTH CARE PROGRAM

Art. III, 9(c)(1)(ii)

(ii) Age. The child must not have reac d the end of the calendar year in which ıe child becomes age 19, unless such child ıas been determined to be totally and perr nently disabled prior to the end of tha year or is a full-time student, as indicateu below.

For the purposes of this subsection, "totally and permanently disabled" means having any medically determinable physical or mental condition which prevents the child from engaging in substantial gainful activity and which can be expected to result in death or be of long-continued or indefinite duration.

In case of dispute over the nature of the condition, the Corporation's Medical Director's decision shall be final.

Coverage will not be reinstated for a child who first becomes totally and permanently disabled after the end of the calendar year in which age 19 is attained or who was eligible for coverage as a totally and permanently disabled child, recovers, and, after the end of such calendar year again becomes so disabled.

A child who has reached the end of the calendar year in which such child turns age 19, has not reached the end of the calendar year in which such child turns age 25 and has not been identified as totally and permanently disabled, will satisfy this age requirement only if such child is a full-time student for at least five months during the calendar year. While the child continues to maintain such student status, coverage may be continued, but in no event beyond the end of the calendar year in which such child turns age 25.

SALARIED HEALTH CARE PROGRAM

Art. III, 9(c)(1)(iii)

(iii) Marital Status. The child must be unmarried.

(iv) Residency. The child must reside with the primary enrollee, as a member of such enrollee's household. A child temporarily away from home while attending school will be deemed to meet this residency requirement.

The residency requirement also will be deemed to be met if the child is not a member of the primary enrollee's household, but the primary enrollee is legally responsible, pursuant to a court order, for the provision of health care for the child. However, if the legal responsibility is established pursuant to a paternity order or any other order which does not meet the requirements for a QMCSO under OBRA '93, the non-resident child must meet the dependency definition in subsection (a)(1), above.

(2) An eligible surviving spouse may not enroll a child unless the child was eligible to be enrolled prior to the death of the employee or retiree or, in the case of a child born after the death of the employee or retiree, unless such child is the issue of the surviving spouse's marriage to the deceased employee or retiree, and was conceived prior to such employee's or retiree's death.

(3) The effective date of coverage for a child shall be the later of the effective date of coverage for the primary enrollee, or in the case of:

(i) A birth - the date of birth;

(ii) A legal adoption - the date the adoptive parent(s) takes physical custody of the child pursuant to the adoption process, or an earlier date if required under OBRA '93; and

SALARIED HEALTH CARE PROGRAM

Art. III, 9(c)(3)(iii)

(iii) A stepchild - the date the child becomes a member of the employee's or retiree's household.

(4) A child, as defined above, shall cease to be eligible for coverage as of:

(i) the date of marriage of such child;

(ii) the last day of the month in which the child ceases to meet the residency criteria of subsection (c)(1)(iv) above;

(iii) the last day of the calendar year in which the child becomes age 19, except in the case of a totally and permanently disabled child (in which case, eligibility shall cease as of the last day of the month in which the child ceases to be totally and permanently disabled as defined by this Program or fails to satisfy other criteria for continuing coverage) or in the case of a child who is a full-time student at least five months during each calendar year (in which case coverage may be continued for such years but in no event beyond the end of the year the child turns age 25);

(iv) the date the primary enrollee's coverage ceases, except that, in the case of the primary enrollee's death, coverage for such child shall cease on the last day of the month in which the primary enrollee dies, unless such child is eligible for coverage as a dependent child of the surviving spouse of such employee or retiree; or

(v) the last day of the month in which the child ceases to be dependent upon the primary enrollee, for children whose eligibility is being continued under the "guardianship" or "principally supported child" provisions of a prior Program.

SALARIED HEALTH CARE PROGRAM

Art. III, 9(d)

(d) Sponsored Dependents

Any dependent, including a spouse, acquired by a retiree on or after July 1, 1988, will be limited to coverage as a sponsored dependent. A dependent is not "acquired" after retirement if the dependent's legal relationship with the primary enrollee was established prior to the primary enrollee's retirement and has existed continuously thereafter.

(1) A primary enrollee (other than one classified as a Flexible Service Employee or a Cooperative Student) may obtain core coverages (other than Extended Care Coverage) for certain dependents other than those specified in subsections (b) and (c) above. Such dependents shall be limited to: (i) children of the primary enrollee or the primary enrollee's spouse who reside with the primary enrollee but who are ineligible for coverage as dependent children due to age, (ii) children residing with the primary enrollee and who are the children of individuals who themselves are eligible and enrolled for coverage as dependent children of the primary enrollee, (iii) children whose parents are both deceased, who reside with the primary enrollee and for whom the primary enrollee and/or the primary enrollee's spouse is the legal guardian pursuant to a court order, (iv) dependent parents of the primary enrollee or primary enrollee's spouse, and (v) a spouse or children acquired after retirement as set forth in subsection (a)(8) above. Before becoming eligible for coverage, sponsored dependents who are not citizens of the United States must reside in the United States for one full year, and must be legally entitled to remain in the United States indefinitely. Sponsored dependents must be dependent upon the primary enrollee as defined in subsection (a)(1) above. They must be designated as sponsored dependents on a valid enrollment form signed by the primary enrollee. The coverages shall be provided under the Program option elected by the primary enrollee.

SALARIED HEALTH CARE PROGRAM

Art. III, 9(d)(2)

(2) Coverages provided under this subsectic for a sponsored dependent enrolled at the ti of n employee's or retiree's death may be c inued at the option of the employee's or retire s surviving spouse while such surviving ouse is eligible o continue, and is enrolle or, coverages as provided in Section 8 o: his Article. A surviving spouse may not dd any new sponsored dependents or add a previously enrolled sponsored dependent who was removed from coverage.

(3) The primary enrollee shall pay the full cost of coverages under this subsection, and the Corporation shall not contribute toward the cost of health care coverages for any sponsored dependents.

(4) The effective date of coverages for an eligible sponsored dependent shall be the later of the effective date of coverages for the primary enrollee, or the first day of the month following the month of receipt by the Corporation of a completed enrollment form and any supporting documentation as may be required by the Corporation. However, the effective date for a sponsored dependent previously enrolled as such, and whose coverages as a sponsored dependent were discontinued, shall be the first day of the sixth month following the month in which the application for reinstatement is received.

(5) Each sponsored dependent enrolled under an option that requires deductibles or copayments shall be subject to separate deductibles and copayments as specified in Article II, Section 4.

(6) Coverage for a sponsored dependent shall cease on the earliest of:

(i) the last day of the month in wh the person ceases to meet the eligib y criteria set forth in subsection ((1) above,

Art. III, 9(d)(6)(ii)

(ii) the last day of the month preceding the month for which the required contribution was due but not paid,

(iii) the date the primary enrollee's coverages cease except that in the case of the primary enrollee's death, coverage for such sponsored dependent shall cease on the last day of the month in which the primary enrollee dies, unless the sponsored dependent has coverages continued in accordance with subsection (d)(2) above, and

(iv) December 31, 1993 for sponsored dependents who were enrolled as of December 31, 1992, under the provisions of the Program then in effect, but who do not meet the eligibility rules of this Program.

Section 10. Conversion Privilege

(a) Any former enrollee who is no longer eligible to continue coverages under the Program shall be offered an opportunity to obtain other available coverage, on a self-paid basis, from the carrier with which enrolled at the time eligibility terminated. Such conversion privilege shall not apply to prescription drug, hearing aid, vision, dental, or Extended Care Coverages.

(b) A former enrollee wishing to exercise this privilege shall make application to the carrier within 30 days of termination of eligibility under this Program.

Section 11. Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, was implemented January 1, 1987 for salaried enrollees. COBRA provides continuation rights to certain employees or dependents who would ordinarily lose eligibility for coverage under this Program.

SALARIED HEALTH CARE PROGRAM

Art. III, 11(a)

(a) For purposes of COBRA, this Program is considered to be a single plan offering core coverages and non-core coverages, regardless of the coverage option avail ble to and/or chosen by the primary enrollee, and rega dless of the entity chosen by the Corporation to admini: er such coverages on the Corporation's behalf.

(b) The Corporation is responsible for providing notifications, as required under COBRA, to "qualified beneficiaries," as defined therein. The Corporation may delegate the administrative functions associated with COBRA. A qualified beneficiary is responsible for providing notice to the Corporation within 60 days of

(1) divorce or legal separation,

(2) the date an enrolled dependent ceases to qualify as a "dependent child" as defined under Article III, Section 9(c) of this Program,

(3) a Social Security Act determination of Title II or XVI disability at the time of the qualifying event, or

(4) within 30 days of a Social Security Administration determination that a qualified beneficiary is no longer disabled.

Failure to comply with the above notification requirement will result in the loss of eligibility for the affected individual(s) under COBRA.

(c) COBRA continuation coverage is available to employees whose employment is terminated for any reason other than gross misconduct. Any employee separated as a discharge (2A) will be considered to have been terminated for gross misconduct.

(d) The COBRA continuation privileges are available for up to 18 months if coverage is lost due to:

SALARIED HEALTH CARE PROGRAM

Art. III, 11(d)(1)

(1) termination of employment (voluntarily or involuntarily) unless termination is due to gross misconduct, or

(2) reduction of hours (including layoff or leave of absence).

(e) In the event a qualified beneficiary is determined by the Social Security Administration to be disabled at the time of the termination or reduction in hours under Title II or XVI of the Social Security Act, the COBRA continuation privileges are available for up to 29 months if coverage is lost due to:

(1) termination of employment (voluntary or involuntary) unless termination is due to gross misconduct, or

(2) reduction of hours (including layoff or leave of absence).

(f) COBRA continuation is available for up to 36 months to:

(1) spouses who lose coverage because of the employee's or retiree's death or because of divorce from the employee/retiree, and

(2) dependent children who become ineligible under Article III, Section 9(c) of the Program.

(g) COBRA continuation is not available to sponsored dependents, individuals covered under another employer sponsored group health plan (unless, after December 31, 1989, the other employer sponsored group health plan precludes coverage for a pre-existing condition of the qualified beneficiary) or individuals eligible for Medicare.

(h) The option to elect continued coverage under this Program through COBRA provisions requires the enrollee to self-pay at 102% (150% in certain cases) of the full cost of elected coverage.

SALARIED HEALTH CARE PROGRAM

Art. III, 11(i)

(i) To the extent the Corporation makes alternativ continuation privileges ("Program Continuatior available that do not satisfy all the requiren ts for COBRA continuation coverage, enrollees shall h ve the opportunity to elect either COBRA continuatic coverage or Program Continuation. An election of COF A continuation coverage automatically will te inate the enrollee's eligibility for Program Continua on.

(j) To the extent the Corporation makes Program Continuation privileges available that do satisfy all of the requirements for COBRA continuation coverage, such Program Continuation will be integrated with the COBRA continuation coverage.

(k) In the event a primary enrollee is entitled to elect between COBRA continuation coverage and Program Continuation, coverage will be continued beyond the point coverage as an active employee or dependent of an active employee ceases as if the primary enrollee elected Program Continuation, subject to the enrollee's fulfillment of all requirements of such continuation.

If the primary enrollee subsequently elects COBRA continuation during the election period described in subsection (m) below, and pays any required contribution, coverages will be adjusted retroactively to provide the COBRA continuation.

(l) Unless advised otherwise by a COBRA qualified beneficiary, an election of Program Continuation by the primary enrollee shall be presumed to be an election for all other enrollees and/or qualified beneficiaries covered under such primary enrollee's coverage.

(m) The election period for COBRA continuation begins on the date on which coverage would terminate due to a qualifying event and must be 60 days in length. However, the election period ends the later of 0 days from the qualifying event or 60 days from the tual notice to the qualified beneficiary. Nothing . this provision relieves a qualified beneficiary from ne obligations or implications of subsection 11(b) ove.

SALARIED HEALTH CARE PROGRAM

Art. III, 11(n)

(n) In all cases, COBRA continuation coverage commences on the first day of the month following the month in which the qualifying event occurred.

(o) COBRA continuation ceases on the earliest of:

(1) 18 months from the date COBRA continuation coverage commences for employees whose employment has been terminated or reduced in hours; however, this may be extended up to 29 months (i.e., for an additional 11 months) for a qualified beneficiary who has been determined by the Social Security Administration to be disabled with a Title II or XVI disability at the time of the qualifying event and who remains disabled;

(2) 36 months from the date COBRA continuation coverage commences for any other qualifying event;

(3) the first of the month for any month in which a required contribution is due but not paid;

(4) the date a qualified beneficiary becomes covered under another employer-based health care plan (for qualifying events before January 1, 1990);

(5) the date a qualified beneficiary is covered under another employer-based health care plan (for qualifying events after December 31, 1989) which does not preclude coverage for a pre-exisiting condition of the qualified beneficiary;

(6) the date a qualified beneficiary becomes eligible for Medicare; and

(7) the date coverage is terminated for all employees.

(p) Conversion contracts, as described in Section 10 above, are available to COBRA continuation coverage enrollees at the time their continuation period is exhausted.

ARTICLE IV

DEFINITIONS

Unless otherwise indicated, as used in this Program:

1. "active service" or in "active service" - means at work and receiving compensation for periods of work scheduled by the Corporation, or otherwise scheduled to work but absent due to,

   (a) attendance at school as a GM Fellow or as a GM-sponsored cooperative student,

   (b) vacation time authorized in advance,

   (c) a specified holiday,

   (d) "compensable disability" leave of absence,

   (e) short-term casual absence, whether scheduled or unscheduled, under circumstances where the employee is entitled to receive full or partial compensation, or

   (f) bereavement, jury duty, or short-term military leave of absence under circumstances where the absence is authorized in advance and the employee is entitled to receive full or partial compensation from the Corporation for the day(s) of absence.

   An employee is not in active service if the employee is absent every scheduled work day during a month, for reasons other than those specified above, whether or not such absence is excused, if the employee is not entitled to receive compensation for such absent time.

   An employee is not in active service in any full month in which such employee is not scheduled to work due to layoff or any leave of absence (other than short-term military leave referred to in subsection (f) above), regardless of whether the employee may be entitled to some compensation for any day(s) during such month.

SALARIED HEALTH CARE PROGRAM

Art. IV, 2

2. "benefit" - means a payment made, in accordance with the Program provisions, to an enrollee, or to a provider on behalf of an enrollee.

3. "carrier" - means any entity by which Program coverages are administered or benefits are paid. The term includes, but is not limited to, the following types of entities:

(a) an insurance company

(b) a Blue Cross or Blue Shield Plan

(c) a dental plan

(d) a group practice plan or health maintenance organization

(e) a preferred provider organization

(f) General Motors Corporation

(g) a non-governmental administrative services organization.

4. "cost of coverages" - means the Corporation's reasonable estimate of the monthly amount required to provide coverages for an individual or group of individuals, established on an actuarial basis taking into account such factors as enrollment classification [self only, self and spouse, self and child (children), self and family], health care option (BMP, EMP, PPO, or HMO), scope of coverages (what services are covered), regional cost differences and administrative costs. It includes both the Corporation contribution and any primary enrollee contribution(s), as required under the Program. The cost is accrued and reported on a monthly basis. In the case of coverages delivered through certain pre-payment agencies, such as a health maintenance organization or an alternative dental plan, it means the total monthly premium required to provide such coverages.

SALARIED HEALTH CARE PROGRAM

Art. IV, 5

5. "coverage" - means a specified set of health care services or expenses (i.e., "covered services or expenses") which may be incurred by an enrollee and for which benefits may be paid under the Program provisions. The categories of coverage include "core" coverages (hospital, surgical, medical, hearing aid, prescription drug, mental health and substance abuse, and Extended Care Coverage) and "non-core" coverages (dental and vision).

Not every health care expense incurred by an enrollee falls within the Program coverages.

6. "covered service" - means a service that is included within the range of services identified in the Program, and that meets all Program requirements to be eligible for payment of benefits. A service within the range of those identified in the Program (e.g., a diagnostic radiology service) but which does not meet all of the specifications to be eligible for benefit payment (e.g., if it is an experimental service or if it is not medically necessary) is considered a non-covered service.

7. "effective date" - means the date on which a given coverage begins for an enrollee, as determined by the Corporation, consistent with the Program provisions.

8. "employee" -

(a) means certain persons employed in the United States by the Corporation or by a wholly-owned or substantially wholly-owned domestic subsidiary thereof, under policies established by the Corporation and set forth in administrative manuals addressing such policies, on a salaried or other basis, herein referred to as "salaried employees", as follows:

(1) "Regular Active" - individuals employed on a full-time basis;

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Art. IV, 8(a)(2)

(2) "Flexible Service" and "part-time" - employees who, on a regular and continuing basis, perform jobs having definitely established working hours, but the complete performance of which requires fewer hours of work than the regular work week, provided the services of such employees are normally available and utilized for at least half of the employing unit's regular work week [see Article II, 4(e)(2) for a description of coverages];

(3) "GM Fellows" - individuals attending graduate school full-time under the GM Fellowship Plan;

(4) "Cooperative Students" - individuals participating in a Corporation-authorized cooperative education program pursuing a degree at a college or university [see Article II, 4(e)(3) for a description of coverages]; and

(5) "International Service Personnel" - individuals working in a foreign country [see Article II, 4(e)(1) for a description of coverages].

(b) The term "employee" shall not include:

(1) employees represented by a labor organization which has not signed an agreement making the Program applicable to such employees;

(2) employees of any directly or indirectly wholly-owned or substantially wholly-owned subsidiary of the Corporation acquired or formed by the Corporation on or after January 1, 1984 (e.g., Hughes, Saturn or Electronic Data Systems) unless specifically included by the General Motors Corporation Board of Directors;

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Art. IV, 8(b)(3)

(3) "leased employees" as defined under Section 414(n) of the Internal Revenue Code; or

(4) individuals employed on a temporary or per diem basis.

(c) To the extent a labor organization has signed an agreement with the Corporation, and under such agreement certain employees represented by such labor organization are excluded from the Program in whole or in part, such represented employees shall be regarded as employees for the purposes of this Program only to the extent required to comply with such agreement.

9. "employer" - means General Motors Corporation.

10. "enrollee" - means a person who is eligible for coverages under the Program and who is enrolled for such coverages. Depending upon the context, an enrollee may be a "primary enrollee" or a "secondary enrollee." The determination of eligibility in a manner consistent with the Program provisions is the responsibility of the employer.

"primary enrollee" - means an employee, retiree or surviving spouse eligible in such individual's own right.

"secondary enrollee" - means a spouse, child or sponsored dependent entitled to coverage by virtue of the individual's relationship to a primary enrollee.

11. "layoff" - means a layoff as provided for under the Corporation's salaried policies, resulting from a reduction in force or from the discontinuance of a plant or operation.

12. "Medicare" - means the Federal program established by Title XVIII of Public Law 89-97, as amended, which provides health insurance for the aged and disabled. It includes Part A (Hospital Insurance Benefit for the Aged and Disabled) and Part B (Supplementary Medical Insurance Benefit for the Aged and Disabled).

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Art. IV, 13

13. "Plan" - means a particular coverage or group of coverages under the Program; the "Medical Plan" is comprised of that portion of the Program providing Appendix A (hospital, surgical, medical, prescription drug, hearing aid, etc.) and Appendix B (mental health and substance abuse) coverages; the "Dental Plan" is that portion of the Program providing Appendix C coverage; and the "Vision Plan" is that portion of the Program providing Appendix D coverage.

14. "provider" - means a physician, hospital, or other approved facility, agency or individual who is qualified to render service(s) or furnish materials under this Program.

15. "reasonable and customary charge" as it relates to covered expenses, unless otherwise specified, means the actual amount a provider charges for such services rendered or materials furnished, but only to the extent that the amount is reasonable, as determined by the carrier, taking into consideration, among other factors, the following:

    1. the usual amount which the individual provider most frequently charges the majority of patients or customers for a similar service rendered or materials furnished;

    2. the prevailing range of charges made in the same geographic area by providers with similar training and experience for the service rendered or materials furnished; and

    3. unusual circumstances or complications requiring additional time, skill, and experience in connection with the particular service rendered or materials furnished.

    The carrier is responsible for determining the appropriate reasonable and customary charge for a given provider, service or material. The carriers shall have

SALARIED HEALTH CARE PROGRAM

Art. IV, 15

discretionary authority to interpret apply and construe this provision of the Progr n. The determination by the carrier as to e reasonable and customary charge shall be final and onclusive, and shall be given full force and effe unless it is determined by the Program Administ ator to have been contrary to the Program provision or it is proven that the determination was arbitrary and capricious.

As used in this Program, reasonable and customary also refers to the forms and/or amount of payment used by carriers and preferred provider or similar organizations to reimburse participating or contracted providers for covered services.

16. "service" or "length of service" - means that period of employment with the Corporation or any of its wholly-owned subsidiaries which is considered unbroken by the Corporation as determined by its salaried personnel policies and procedures.

ARTICLE V

SPECIAL BENEFIT

Section 1. Eligibility for the Special Benefit

(a) In order to be eligible for a Special Benefit under this Article V, an individual must be:

(1) an employee eligible for Extended Disability Benefits under the General Motors Life and Disability Benefits Program for Salaried Employees, or

(2) a retired employee (other than a deferred vested retiree) who retired on or after October 1, 1979, or

(3) a surviving spouse (but not the surviving spouse of a former employee eligible for a deferred retirement benefit, or a surviving spouse or surviving divorced spouse eligible for a pre-retirement survivor benefit under Part A, Article I, Section 5(j) of the General Motors Retirement Program for Salaried Employees);

and must be:

(4) age 65 or older, or

(5) if under age 65, enrolled in Medicare Part B; and must be:

(6) receiving a monthly retirement benefit (which commenced on or after October 1, 1979) under the General Motors Retirement Program for Salaried Employees, or

(7) receiving a monthly Extended Disability Benefit under the General Motors Life and Disability Benefits Program for Salaried Employees (or eligible for such a benefit but not receiving it due to reductions under that Program).

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Art. V, 1(b)

(b) Neither an employee who retires from the status of a Flexible Service Employee, a Cooperative Student or an International Service Personnel employee, nor such a person's surviving spouse, is eligible for a Special Benefit.

Section 2. Amount of the Special Benefit

(a) Subject to subsections 2(b) and (c), below, an individual identified in subsection 1(a) above, shall be eligible to receive a monthly Special Benefit equal to the lesser of the generally applicable Medicare Part B premium in effect as of January 1, 1994, or $41.10, for months commencing on or after January 1, 1994. Such amount may be adjusted by the Corporation from time to time.

(b) Retirees and surviving spouses eligible for Medicare Part B coverage on or after March 1, 1988, must be enrolled in Medicare Part B as a condition for receipt of the Special Benefit. Retirees and surviving spouses who first became eligible prior to March 1, 1988, and who were receiving the Special Benefit but were not enrolled in Medicare Part B on October 1, 1990, comprise a group of Special Benefit recipients who are not required to enroll in Medicare Part B in order to continue receipt of a Special Benefit. However, individuals in this group will not have their Special Benefit amount increased from $28.00 per month. These individuals may qualify for the increased Special Benefit amounts by presenting proof of Medicare Part B enrollment.

(c) Any recipient who is enrolled in Medicare Part B coverage and discontinues such coverage will have the Special Benefit discontinued for periods during which Medicare Part B enrollment is not maintained.

Section 3. Payment of the Special Benefit

(a) No Special Benefit shall be payable for months prior to March 1, 1974. Thereafter, payment shall commence on the earlier of:

SALARIED HEALTH CARE PROGRAM

Art. V, 3(a)(1)

(1) the first day of the month following the month during which age 65 is attained, [subject to the provision set forth in subsection 2(b) above], or

(2) the first day of the month in which an otherwise eligible individual under age 65 becomes enrolled for Medicare Part B.

Individuals under age 65 must make application to the Corporation on a form provided for this purpose.

(b) Payment of the Special Benefit will be made concurrent with a monthly retirement or Extended Disability Benefit payment and for the same period. In the event an eligible employee receives no monthly Extended Disability Benefit payment because of reductions under the General Motors Life and Disability Benefits Program for Salaried Employees, a Special Benefit will be paid for that month.

(c) Not more than one Special Benefit payment shall be made to any individual for any one month, under this or any other General Motors benefit Plan or Program.

(d) No Special Benefit payment shall be made to any individual under age 65 for any month in which such individual is not enrolled for Medicare Part B coverage.

APPENDIX A

HOSPITAL, S GICAL, MEDICAL,
PRESCRIPTION DRUG AND HEARING AID COVERA

I. Definitions

As used herein:

A. "accidental injury" means a bodily injury such as a strain, sprain, abrasion, contusion or other condition which occurs as the result of a traumatic incident such as, but not limited to: ingestion of poison; overdose of medication, whether accidental or intentional; allergic reaction resulting from trauma, such as bee stings or insect bites; inhalation of smoke, carbon monoxide, or fumes; burns, frostbite, sunburn, and sunstroke; and attempted suicide.

B. "ambulance services" means medically necessary transportation and life support services furnished within the Program provisions to sick, injured or incapacitated patients by a licensed ambulance provider meeting Program standards, utilizing ambulance vehicles and personnel recognized as qualified to perform such services at the time and place where rendered.

C. "approved" - see "participating"

D. "benefit period" means a period of time during which an enrollee is entitled to receive certain covered services which are subject to Program maximums (see App. A, II.B. and App. B, II.B.). The services which may be subject to maximums include, but are not limited to, inpatient hospital services (with special provisions for pulmonary tuberculosis treatment under this Appendix, and mental health and substance abuse treatment under Ap endix B), admissions to skilled nursing facilities (wh er under this Appendix or Appendix B), treatment unde sychiatric day care or night care programs (and substan buse day care or night care programs), substance abuse lfway house programs (under Appendix B) and hospice e.

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App. A, I. E.

E. "covered expenses" means the reasonable and customary, preestablished, or contracted charges incurred for covered materials and services, as described in Section III of this Appendix, provided or rendered to or for an enrollee for treatment of illness or injury, and performed by a provider or prescribed by a physician in accordance with the provisions of this Program. Such covered expenses fall in the following areas of coverage or categories of expenses:

1. hospital expenses;
2. skilled nursing facility expenses;
3. physical, speech and functional occupational therapy and cardiac rehabilitation expenses;
4. home health care expenses;
5. medical, surgical expenses;
6. ambulance service expenses;
7. prescription drug expenses;
8. hearing aid expenses;
9. durable medical equipment and prosthetic or orthotic appliance expenses; and
10. hospice expenses.

F. "custodial" or "domiciliary" care or services means the type of care or service which, even if ordered by a physician, is primarily for the purpose of meeting personal needs of the patient or maintaining a level of function (as opposed to specific medical, surgical or psychiatric care or services designed to reduce the disability to the extent necessary to enable the patient to live without such care or services). Custodial or domiciliary care generally does not require the continuing attention of medically skilled personnel, and usually can be provided by aides or other persons without special skills or training, operating without direct medical supervision. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, toiletting, meal preparation and eating, taking of medications, ostomy care, bed baths, hygiene or incontinence care, checking of routine vital signs, routine dressing changes and routine skin care. The determination as to the nature of the care is not a function of the setting (e.g.- hospital, skilled nursing facility, nursing home, another institutional setting or the patient's home) or of the professional status of the person (e.g.- physician, nurse, therapist or aide) rendering the service, but of the severity of the

App. A, I. F.

patient's illness and the intensity of services being performed. The carriers shall have discretionary authority to interpret, apply and construe this provision of the Program. The carrier's determination as to the nature of the care being provided shall be given full force and effect unless it is determined by the Plan Administrator that the determination was inconsistent with the Program provisions or arbitrary and capricious.

G. "domiciliary" - see "custodial"

H. "drugs, biologicals, and solutions" means medicinal agents which are approved for commercial distribution by the Federal Food and Drug Administration and are legally prescribed for the treatment of an illness or injury.

I. "durable medical equipment" means equipment which is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to an enrollee in the absence of illness or injury.

J. "freestanding outpatient physical therapy facility" means a facility, separate from a hospital, which provides outpatient physical therapy services. Such facilities must meet Program standards and be approved by the local carrier.

K. "functional occupational therapy" - see "physical therapy"

L. "home health care" means care or services provided in the home for a patient whose condition does not warrant care in an institutional setting (such as a hospital or skilled nursing facility). The care/services may be skilled or unskilled in nature.

M. "home health care agency" means a centrally administered agency providing physician-directed nursing and other paramedical services to patients at home. A home health care agency must meet Program standards and be approved by the local carrier.

App. A, I. N.

N. "hospice" means a program of medical and non-medical services provided for terminally-ill enrollees and their families through agencies which administer and coordinate the services. A hospice program must meet Program standards and be approved by the local carrier.

O. "hospital" means a facility which provides diagnostic and therapeutic services on a continuous inpatient basis for the surgical, medical, or psychiatric diagnosis, treatment, and care of injured or acutely sick persons.

These services are provided by, or under the supervision of, a professional staff of licensed physicians and surgeons. A hospital continuously provides 24 hour-a-day nursing service by registered nurses. A rehabilitation institution shall be considered to be a hospital if the institution is approved as such under this Program. A hospital must meet all applicable local and state licensure and certification requirements and be accredited as a hospital by state or national medical or hospital authorities or associations.

A hospital is not, other than incidentally, a place for custodial, convalescent, pulmonary tuberculosis, rest or domiciliary care; an institution for exceptional children; an institution to which enrollees may be remanded by the judicial system; an institution for the treatment of the aged or substance abusers; or a skilled nursing facility or other nursing care facility. It does not include a health resort, rest home, nursing home, convalescent home, or similar institution.

P. "medical emergency" means a permanent health-threatening or disabling condition, other than an accidental injury, which requires immediate medical attention and treatment.

The condition must be of such a nature that severe symptoms occur suddenly and unexpectedly and that failure to render treatment immediately could result in significant impairment of bodily function, cause permanent damage to the enrollee's health, or place such enrollee's life in jeopardy. The enrollee's signs and symptoms verified by the treating physician at the time of treatment, and not the final diagnosis, must confirm

the existence of a threat to the enrollee's life or bodily functions. The carriers shall have authority to construe, interpret and apply this provision of the Program. The carrier's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to be inconsistent with the Program provisions or arbitrary and capricious.

Q. "non-physician practitioners" means individuals other than physicians who are legally qualified and licensed to perform certain health care services. The following categories of non-physician practitioners may be eligible for reimbursement for services within their area of expertise. To be eligible for reimbursement, they must meet Program standards (including eligibility for reimbursement by Medicare for Medicare-eligible patients) and be approved by the carrier.

1. "certified registered nurse anesthetist" means a registered nurse trained in the administration of anesthetics.

2. "physical therapist" means an individual trained in the evaluation and rehabilitation of injured or disabled enrollees through non-medical and non-surgical measures.

3. "functional occupational therapist" means an individual trained in the restoration of a specified level of function of injured or disabled enrollees through non-medical and non-surgical measures.

4. "speech therapist" means an individual trained in the correction of speech and language disorders through non-medical and non-surgical measures.

R. "orthotic appliance" means an external device intended to correct any defect of form or function of the human body.

S. "participating" or "approved" means any hospital, skilled nursing facility, outpatient physical therapy facility, home health care agency, physician, or other provider of health care services which, at the time an enrollee

receives services included under this Program, has entered into a contract or agreement with a carrier to provide those health care services in accordance with this Program. Such contract or agreement shall include a provision that the provider accepts the amount of covered expense, as determined by the carrier, as payment in full (unless otherwise provided). A physician who is not a participating physician may participate for individual claims.

T. "physical therapy" and/or "functional occupational therapy" mean therapy directed toward improving or restoring the level of musculoskeletal function lost due to illness or injury, to the development of new function attainable following surgery, or, if for a chronic or congenital condition, to significantly improve the condition in a reasonable and predictable period of time. Physical therapy generally pertains to large muscle use and functional occupational therapy to fine motor activities.

U. "physician" means a doctor of medicine (M.D.) or osteopathy (D.O.) legally qualified and licensed to practice medicine or osteopathic medicine and/or perform surgery at the time and place services are rendered or performed. As used herein, physician shall also include the following categories of limited-practice professionals who are legally qualified and licensed to practice their specialties at the time and place services are performed, and who render specified services which they are legally qualified to perform.

1. "dentist" means a doctor of dental surgery (D.D.S.) or a doctor of medical dentistry (D.M.D.) whose scope of practice is the diagnosis, prevention and treatment of diseases of the teeth and related structures. Such services are provided for under the dental coverage (see App. C of the Program). However, certain services of a dentist may be covered under this Appendix when performed for a hospital inpatient when a concurrent hazardous medical condition exists (see App. A, III.E.3.a.(2)) or when performed in response to a medical diagnosis and when Program standards are met. A dentist also may prescribe medications which may be covered under the prescription drug coverage (see App. A, III.G.).

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App. A, I. U.2.

2. "podiatrist" means a doctor of podiatric medicine (D.P.M.) or a doctor of surgical chiropody (D .C.) whose scope of practice is the diagnosis, pre ention, and treatment of ailments of the feet. Servi es of podiatrists, relating to the foot (including the ankle), may be covered under the surgical and medical coverages (see App. A, III.E.). A podiatrist also may prescribe medications which may be covered under the prescription drug coverage (see App. A, III.G.).

3. "chiropractor" means a doctor of chiropractic (D.C.) whose scope of practice is the diagnosis and treatment of subluxations or misalignments of the spinal column and related bones and tissues which produce nerve interference. Services of chiropractors which may be covered are limited to diagnostic radiological services (see App. A, III.E.3.j.) and emergency first-aid (as set forth in an administration manual published by the Control Plan), both pertaining to the spine and related bones and tissues.

Under this Program, a chiropractor may not prescribe medications or perform invasive procedures or incisive surgical procedures, nor perform physical examinations not related to the spine and related bones and tissues.

V. "private duty nursing" means care or services provided by a nurse pursuant to a contract with a patient and/or a patient's family/personal representative. The services may be skilled or unskilled, therapeutic or custodial in nature and may be provided in any setting. Generally, the care contracted for is in excess of the care provided by an institution (such as a hospital or skilled nursing facility) or the part-time/intermittent/skilled care provided by a home health care agency.

W. "private room" means a room containing one bed.

X. "Program standards" means criteria established by the Control Plan (and approved by the Corporation) for approval of providers or for benefit payment. At a

minimum, providers must meet applicable accreditation, licensing and credentialing requirements and be qualified to render services or furnish materials under this Program. In the case of provider approval, standards also may include, but are not necessarily limited to, such matters as approval for Medicare reimbursement and acceptance of Medicare assignment and/or Program reimbursement as payment in full. In the case of benefit payment, standards may include, but are not necessarily limited to, such matters as the service or item being approved by Medicare and/or the service or item being delivered or prescribed in response to particular diagnoses. Local carriers shall be responsible for establishing whether local providers conform to such standards, or for obtaining approval of exceptions through the Control Plan.

Y. "prosthetic appliance" means an artificial device which replaces an absent part of the body, or which aids the performance of a natural function of the body without replacing a missing part.

Z. "rehabilitation care" means services within an acute care hospital or skilled nursing facility for intensive rehabilitation through a multidisciplinary, coordinated team approach. Such care is provided on an inpatient basis for patients found to have significant functional disability resulting from the recent onset of an acute condition (such as a broken hip or a stroke) or exacerbation of a chronic condition (such as rheumatoid arthritis), where there is a reasonable expectation for significantly increased function as a result of aggressive, inpatient, multi-modality rehabilitation services.

AA. "semiprivate room" means a room containing two beds.

BB. "service" means any care or procedure, as listed and limited herein, which is provided for diagnosis or treatment of disease, injury or pregnancy and which is based on valid medical need according to accepted standards of medical practice. Certain types of care or procedures may be excluded as covered services under this Program.

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App. A, I. CC.

CC. "skilled nursing care" means care or services which are prescribed by a physician and furnished by a licensed registered nurse (RN) or licensed practical nurse (LPN). The services may be provided on a continuous (as in a hospital or skilled nursing facility) or on an intermittent/part-time basis. The patient must be under treatment and/or convalescing from an illness or injury which requires ongoing evaluation and adjustment of care. The nature of the service and skills required for safe and effective delivery, rather than the patient's medical condition, determine whether the service is skilled.

Examples include, but are not limited to: administration of intravenous fluids and medications; suctioning; dressing changes for major post-operative wounds and dressing changes for infected lesions which require irrigation and/or medication and/or sterile dressings; catheterizations; ventilator care; cardio-pulmonary assessments; and colostomy/cystostomy care. The carriers shall have discretionary authority to interpret, apply and construe this provision of the Program. The carrier's determination as to the nature of care being provided shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with Program provisions or arbitrary and capricious.

DD. "skilled nursing facility" means a facility providing convalescent and long-term illness care with continuous nursing and other health care services by, or under the supervision of, a physician and a registered nurse. The facility may be operated either independently or as part of an accredited general hospital. A skilled nursing facility must meet Program standards and be approved by the local carrier.

EE. "special care unit" means a designated unit within a hospital (such as cardiac care, burn care, or intensive care unit) that concentrates all necessary types of equipment together with skilled nursing and supportive services needed for care of critically ill patients and is recognized as such by the carrier.

FF. "speech therapy" means therapy to restore the functional loss of speech resulting from an organic medical condition.

App. A, I. GG.

GG. "therapeutic care" means specific and definitive surgical, medical, psychiatric or other care provided to a patient whose condition continues to improve due to the treatment being received. It is provided with the expectation that the patient's level of disability will be reduced, within a reasonably predictable period of time, to enable the patient to function without such care. The improvement must be observable and documented by objective measurement. If a patient's condition stabilizes and further improvement is not reasonably predictable, continuing care will be considered maintenance in nature. The carrier's determination as to the nature of the care shall be given full force and effect unless it is determined by the Plan Administrator to have been contrary to the Program provisions or arbitrary and capricious.

II. Terms and Conditions

A. Payment of Benefits

1. Benefits will be payable, subject to the provisions of this Program, when an enrollee incurs a covered expense.

2. Under the Program, benefits for certain covered services are payable only if approved by the carrier and/or if furnished by approved providers, when applicable. If such approval is not obtained, or if such providers are not utilized, benefits for such services may be reduced or eliminated. Examples include, but are not limited to, failure to comply with the predetermination requirements or failure to utilize panel providers.

B. Benefit Period Provisions

1. An enrollee is entitled to a maximum of:

a. 365 days of covered inpatient hospital services for each continuous period of hospital confinement or for successive periods of confinement within a benefit period; however,

(1) the inpatient treatment of pulmonary tuberculosis is limited to 45 days of the benefit period; and

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App. A, II. B.1.a.(2)

(2) the inpatient treatment of mental disorders and substance abuse (a set forth in Appendix B) is limited . . days of the benefit period;

b. 210 days (lifetime maximum) of hospi care; and

c. two days of inpatient skilled nursi . facility care for each remaining day of inpat .ent hospital care within the benefit period, to a maximum of 730 days for each continuous period of confinement or for successive periods of confinement within a benefit period. Each day of inpatient hospital care within a benefit period reduces by two the number of days of care available for skilled nursing facility services. Use of days of care in a skilled nursing facility does not reduce the number of days of inpatient hospital care.

2. Benefit periods for physician services and medical care related to hospital inpatient admissions and skilled nursing facility admissions are related to or may be determined concurrent with the benefit periods for facility services as noted below:

a. For conditions other than pulmonary tuberculosis, an enrollee is entitled to coverage for medical care for the duration of a hospital or skilled nursing facility admission.

b. Coverage of medical care for pulmonary tuberculosis is limited to 45 days for the treatment of tuberculosis for each continuous period of confinement or for confinements separated by less than 60 days.

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App. A, II. B.3.

3. Benefit periods may be renewed, subject to the following:

a. To be eligible for further benefits under each of the subsections, there must be a separation of 60 days between periods of hospitalization for any reason. For example, if an enrollee's initial inpatient admission for mental health treatment exhausts the 45-day maximum and is separated by 60 days from a second admission for mental health treatment, but the person had been hospitalized for other reasons during the intervening period, the second mental health admission would not be covered.

b. A new benefit period begins only when the enrollee has been out of care (as described below) for a continuous period of 60 days. Accordingly, there must be a lapse of at least 60 consecutive days between the date of the enrollee's last discharge from any hospital, skilled nursing facility, residential substance abuse treatment facility, or any other facility to which the 60-day benefit renewal period applies and the date of the next admission, irrespective of the reason for the last admission and irrespective of whether or not benefits were paid as a consequence of such admission. Further, if subsequent to such discharge, the enrollee is a patient in a psychiatric or substance abuse day or night care program, a substance abuse halfway house, a hospice program or is receiving home health care services, the 60-day renewal period is broken, whether or not benefits were paid as a consequence of receipt of such services.

C. Access to Information

In order to ensure proper administration and to facilitate the ongoing evaluation of this Program:

1. Enrollees shall authorize providers of services to furnish to the carrier(s), upon request, information relating to services to which the enrollee is, or may be, entitled under this Program.

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App. A, II. C.1.

Providers of services shall be authorized to rmit the carrier(s) to examine their records with spect to the services and to submit reports of the ervices in the detail requested by the carrier(s). l information related to treatment of the enro lee will remain confidential except for the purpose determining rights and liabilities arising under this Program, or as otherwise required by law or pursuant to a written authorization by the patient.

2. A provider claiming payment from the carrier must furnish a report to the carrier, in the prescribed form, within 180 days from the date of the last continuous service listed on the report as having been rendered to the enrollee. The provider must certify upon the report that the provider is entitled to payment under this Program and that the service was personally rendered or rendered during the provider's presence and under the provider's supervision. An enrollee's request for service is authorization to the provider to make the report.

3. An enrollee seeking payment from a carrier must furnish, or cause the provider to furnish, a report to the carrier in the form prescribed by the carrier. By filing the report the enrollee consents that the carrier may have access to the data disclosed by the records and files of the provider and of the hospital or other facility named in this report.

D. Identification Cards

1. Enrollees shall be furnished identification cards by the carrier(s). Such cards shall contain toll-free telephone numbers for obtaining predetermination information or other required approvals of services.

2. The identification card must be presented when service is requested.

3. An enrollee shall not use an identification card to obtain benefits to which such enrollee is not entitled, nor shall the enrollee permit another person to obtain benefits to which such person is not entitled.

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App. A, II. E.

E. Medicare

1. Under current Federal laws, certain enrollees otherwise eligible to enroll for benefits under Medicare may defer enrollment in Medicare without penalty. If such enrollees elect to enroll in Medicare, the Program remains the primary source of benefits, with Medicare supplementing Program coverage. For purposes of subsection 2 below, Medicare enrollment of such enrollees shall be disregarded.

2. Coverage under this Program is reduced to the extent that payment is available under Medicare, or to the extent that payment would have been available under Medicare but for the fact that Medicare payment is secondary to coverage provided by a source other than this Program. In the latter event, the maximum liability of this Program will be limited to the balance remaining after the liability of both the primary coverage and Medicare have been determined and benefits paid.

   a. Enrollees who are eligible to enroll for benefits under Part A of Medicare, whether or not they are enrolled, will have all benefits available under this Program reduced to the extent payment or benefit is available (or would have been available had the eligible enrollee been enrolled for Medicare benefits) under Part A of Medicare. The hospital coverage under this Program will be reduced during the additional Medicare 60-day lifetime maximum for inpatient hospital benefits, to the extent the benefits are available under Medicare whether or not the enrollee uses the lifetime reserve.

   b. Enrollees who are enrolled for benefits under Part B of Medicare will have all benefits available under this Program reduced to the extent that payment or benefit is available under Part B of Medicare.

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App. A, II. E.2.c.

c. All benefits furnished under Medicare Part A, or which would have been furnished had the enrollee been enrolled for Medicare Part A benefits, and all benefits furnished under Medicare Part B will be charged against the maximum benefit periods and maximum benefit amounts under this Program. Reduction of coverage under this provision or charging of Medicare benefits against the maximum benefit periods and maximum benefit amounts of this Program will be limited to the benefits provided by Medicare which would have been provided under this Program in the absence of this subsection.

F. Medical Necessity

1. All covered services under the Program are subject to a requirement of medical necessity (see App. A, IV.I.).

2. The Control Plan will establish criteria, where necessary, to define medical necessity and accepted uniform standards of medical practice for the purposes of determining covered services. The Control Plan shall propose such criteria to the Corporation, and when such criteria are approved, shall communicate them to the local carriers. Local carriers shall communicate the criteria to providers.

3. Local carriers, or others, requesting establishment, revision or withdrawal of such criteria shall submit such requests to the Control Plan for consideration. The Control Plan shall advise the Corporation of all such requests and recommended dispositions.

G. Claim Denials

No action or suit at law may be commenced upon or under this Program until 30 days after exhaustion of the applicable appeal procedure described in Article I, Section 6(b). No such action by an enrollee for entitlement to benefits under this Program may be brought more than two years after such claim has accrued.

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App. A, II. H.

H. Changes in the Program

1. From time to time additional coverages may be provided or existing coverages withdrawn by the Corporation by action of its Board of Directors or other committee expressly authorized by the Board to take such action.

2. Neither the Control Plan nor a local carrier may make a substantive change to the coverages or benefits without prior approval of the Corporation. This includes amending administrative practices, policies or interpretations that in the judgment of the Corporation would materially affect the benefits of the Program.

I. Approval of New Services

1. A procedure has been established for implementing the addition of services or items not previously covered under this Program.

2. A proposal for the inclusion in the Program of a new or revised service or item may be submitted to the Control Plan by a carrier, a physician or physician group, a professional organization, a provider or provider group, or the Corporation.

3. The Control Plan shall review such proposal and make a written recommendation to the Corporation regarding whether or not the service or item should be added to the Program. Such recommendation shall include, but not be limited to, the following:

   a. Any quality of care concerns and proposed steps to ensure quality delivery of the service if approved;

   b. Any access concerns and proposed actions to resolve such concerns;

   c. Any concerns over appropriate utilization and proposed actions to resolve such concerns;

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App. A, II. I.3.d.

d. Any service(s) being replaced by the new service, and a plan for discontinuation of coverage for the replaced service; and

e. Positive or negative impact on Program costs.

4. The Corporation shall review and approve or disapprove the Control Plan recommendations. If approval is given and the service is added, an effective date will be established. Only services or items provided on or after the effective date will be covered.

5. The Control Plan will advise local carriers of any approved additions to the Program, the effective dates, and/or limitations or special provisions that apply. The local carriers will advise providers.

J. Participating, Nonparticipating and Departicipating Hospitals

1. When an enrollee's Basic Medical Plan (BMP) or Enhanced Medical Plan (EMP) option is administered by a carrier that has participating agreements with hospital providers, covered services provided to such an enrollee by a nonparticipating hospital (i.e., a hospital with which the carrier does not have a participating agreement), or by a departicipated hospital (i.e., a hospital whose participating agreement ceases, whether at the option of the provider, the carrier or both), are payable in accordance with the provisions set forth, respectively, in J.2. and J.3. below.

2. Benefits for covered services provided by a nonparticipating hospital (other than a psychiatric hospital) shall be payable as follows:

a. Upon admission for a non-emergency condition, payment is limited to $160 per day for inpatient room and board charges and $20 per day for inpatient ancillary charges. Benefits are available for the duration of the admission, but in no event beyond the number of days available under the hospital benefit period. Payment for outpatient services received at such a hospital is limited to $25 for each condition.

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App. A, II. J.2.b.

b. For an emergency admission (as defined by the Program):

(1) Benefits will be payable for the reasonable charges (as determined by the carrier) for ground ambulance transfer to the closest participating hospital capable of handling the case, upon approval of the attending physician and the carrier. This approval must be based on the physician's medical certification that the transfer will not endanger the enrollee's health and of carrier certification that the subsequent stay will be of sufficient duration to justify the transfer.

(2) When the enrollee cannot be safely moved to a participating hospital, the enrollee is entitled to benefits during the first five days of the admission, but in no event beyond the number of days available under the hospital benefit period.

(3) Following the first five days of admission, payment is limited as described in 2.a. above. However, if transfer to a participating hospital cannot be arranged, either because such a transfer would endanger the enrollee's health or because the subsequent stay would not be of sufficient duration to justify transfer, benefits are payable for the duration of such admission, but in no event beyond the number of days available under the hospital benefit period.

c. Admissions to psychiatric hospitals are subject to the provisions of Appendix B of the Program.

3. The carrier will make efforts to notify enrollees of a hospital's departicipation and of the following payment arrangements:

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App. A, II. J.3.a.

a. For an enrollee whose hospital admission commences prior to, or within days following, the date a participating hosp: l departicipates, benefits will paid fo: the duration of such admission, b in no event beyond the number of days ava .able under the hospital benefit period.

b. For an enrollee whose admission to such hospital commences later than 30 days from the date the hospital departicipates, payment for non-emergency admissions is limited as described in 2.a. above and payment for emergency admissions is limited as described in 2.b. above.

c. For an enrollee admitted to a departicipated hospital that regains participating status within six months of departicipating, the carrier will make payment toward the balance of the hospital's reasonable charges (as determined by the carrier) for covered services incurred by the enrollee during the period of departicipation. The carrier shall also arrange that such payment relieves the enrollee of further financial obligation (other than the enrollee's deductible and/or copayment) with respect to covered services received during the departicipation period, and that any portion of such balance previously paid by the enrollee (other than the enrollee's deductible and/or copayment) shall be refunded.

III. Description of Coverages

A. Hospital Coverage

1. Conditions of Benefit Payments

An enrollee is eligible for benefits fo: covered expenses incurred in a hospital only if ne following conditions have been met:

a. The admission and length of stay hav.

(1) predetermination approval from ie carrier for non-emergency, non-maternity admissions of enrolle s in the Basic Medical Plan and Enh: .ced

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App. A, III. A.1.a.(1)

Medical Plan options, as set forth in Article II, Section 4 (emergency and maternity admissions must be reported to the carrier within 24 hours), or

(2) approvals required for enrollees in the Preferred Provider Organization option, as set forth in Article II, Section 4.

b. The admission commences on or after the enrollee's effective date of coverage under the Program.

c. For inpatient hospital services, the enrollee is admitted in accordance with the Program provisions, as administered by the carrier, and the hospital's rules and regulations governing admission as a bed patient, and is under the constant care and treatment of a physician during the period of admission.

d. For inpatient hospital services, the enrollee has benefit days available under the hospital benefit period as set forth in Section II.B. above.

2. Inpatient Hospital Coverage

Upon admission to a participating hospital, or to any hospital for carriers without participating arrangements, an enrollee is entitled to receive the following services when prescribed by the physician in charge of the case, approved by the carrier and provided and billed by the hospital:

a. Semiprivate room, general nursing services, meals, and special diets. Private room coverage will be provided only when such accommodations are medically necessary as set forth in an administration manual published by the Control Plan;

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App. A, III. A.2.b.

b. Use of operating rooms, other surgical treatment rooms, and delivery room
c. Anesthesia when administered by an employee of the hospital and anesthesia supplies, gases, and use of equipment;
d. Laboratory and pathology examinations which are under the direction of a pathologist employed by the hospital;
e. Chemotherapy (chemotherapeutics, antineoplastic agents and administration) for the treatment of malignant diseases by chemical antineoplastic agents except when treatment is research, investigational or experimental in nature (e.g., high dose chemotherapy for a patient with solid tumors of the brain, breast, colon, lung or skin);
f. Physical, speech, and functional occupational therapy (see App. A, III.C.);
g. Oxygen and other gas therapy;
h. Drugs, biologicals, and solutions used while the enrollee is in the hospital;
i. Gauze, cotton, fabrics, solutions, plaster, splints, and other materials used in dressings and casts;
j. Radioactive isotope studies and use of radium when the radium is owned or rented by the hospital;
k. Maternity care and routine nursery care of the newborn during the hospital stay of the mother for maternity care, when the mother is an enrollee;
l. Hospital service in a special care unit;
m. Blood services, including transfusions of whole blood and packed red blood cells (if not replaced), blood derivatives, blood plasma, supplies and their administration;
n. Hemodialysis when provided by a hospital qualified to provide hemodialysis treatment. The carriers shall have discretionary authority to interpret, apply and construe this provision of the Program. The determination of the carrier as to whether or not a hospital is a qualified hospital for providing hemodialysis shall be given full force and effect unless it is determined by

App. A, III. A.2.n.

the Plan Administrator to have been contrary to the Program provisions or arbitrary and capricious;

o. Durable medical equipment (see App. A, III.I.);

p. Prosthetic and orthotic appliances (see App. A, III.I.);

q. Hospital services for sterilization of male or female enrollees regardless of the medical necessity for the sterilization;

r. Hospital services for covered plastic and reconstructive surgery (see App. A, III.E.3.a.(1));

s. Hospital services for abortions regardless of the medical necessity for the abortion;

t. Pulmonary function evaluation;

u. Skin bank, bone bank and other tissue storage bank costs;

v. Inhalation therapy; and

w. Human organ and tissue transplants. For medically recognized human organ or tissue transplants from a living or cadaver donor to a transplant recipient, hospital services (including evaluation tests to establish compatibility and suitability of potential and actual donors when the tests cannot be done safely and effectively on an outpatient basis) are covered as follows:

(1) When the transplant recipient and the donor are both enrollees, benefits are provided for both;

(2) When the transplant recipient is an enrollee, but the living donor is not, benefits are provided for the transplant recipient and, to the extent they are not available under any other health care coverage, for the donor;

(3) When the living donor is an enrollee and the transplant recipient is not, benefits are provided only for the donor;

(4) When the transplant recipient is an enrollee, expenses incurred in the evaluation and procurement of cadaver organs and tissues are benefits when billed by the hospital. All such expenses will be charged to the enrollee's coverage to the extent that they are not covered by any other health care coverage of the donor or potential donor;

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App. A, III. A.2.w.(5)

(5) For purposes of this sub section w. and of App. A, III.E.3.a.(3 "medically recognized" human organ tissu transplants include al eneic b ne marrow for only specif d diagn ses, autologous bone marro or only specified diagnoses, rnea, heart, heart/lung, kidney, er, lung, pancreas and skin. e limitations with respect to bone marrow transplants are contained in Section IV.Z. of this Appendix.

3. Outpatient Hospital Coverage

a. When an enrollee receives outpatient hospital services in a participating hospital, or any hospital for carriers without participating arrangements, which have been ordered by the attending physician and approved by the carrier, the enrollee is entitled to the same coverages available on an inpatient basis, except that:

(1) Drugs, biologicals, and solutions are covered only to the extent they are used in the hospital and administered in connection with the use of operating or surgical treatment rooms, anesthesia, laboratory examinations, or other outpatient hospital services.

(2) Physical, speech and functional occupational therapy also may be covered (see App. A, III.C.).

(3) Chemotherapy (chemotherapeutics, antineoplastic agents and necessary ancillary drugs and their administration) is covere or the treatment of malignant di ses except when the treatment is rese h, investigational or experimer al in nature (e.g., high dose che h py for a patient with solid tum s the brain, breast, colon, lung o skin).

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App. A, III. A.3.a.(3)

Chemotherapy is covered for the following routes of administration: parenteral, continuous or intermittent infusion, perfusion, and intracavitary. Coverage is not available for the oral administration of chemotherapy.

(4) Coverage does not include treatment of chronic conditions which require repeated visits to the hospital, except for hemodialysis.

(5) Services in the emergency room of a hospital are covered for the initial examination and treatment of conditions resulting from accidental injury or medical emergencies. A medical emergency will be considered to exist only if medical treatment is secured within 72 hours after the onset of the condition. Follow-up care is not covered.

(6) Hyperbaric oxygenation is covered when medically necessary for treatment of disease or injury. Coverage is not available for treatment of chronic conditions.

(7) Skin bank, bone bank and other tissue storage bank services are not covered.

b. Hemodialysis (use of kidney machine) or peritoneal dialysis for the treatment of a chronic, irreversible kidney disease is covered in an enrollee's home when services are provided and billed by a hospital which has a hemodialysis program approved by the carrier.

(1) Benefits will not be payable unless the following conditions are met:

(a) treatment must be arranged through the physician attending the enrollee and the physician director or a committee of staff physicians of the training program, and

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App. A, III. A.3.b.(1)(b)

(b) the owner of the enrollee's residence must give written permission to the hospital for installation of the equipment prior to its installation.

(2) The following are covered expenses under this subsection:

(a) purchase, lease, or rental (as determined by the carrier to be appropriate) of a hemodialysis machine placed in the enrollee's home;

(b) installation and maintenance or repair of a hemodialysis machine placed in the enrollee's home;

(c) hospital expenses for training the enrollee and any individual who will be assisting the enrollee in the home setting in operating the hemodialysis machine;

(d) laboratory tests related to the dialysis procedure;

(e) consumable and expendable supplies required during the dialysis procedure, such as dialysis membrane, solution, tubing, and drugs; and

(f) removal of the dialysis equipment from the enrollee's home when the enrollee no longer needs the equipment.

(3) The following are not covered expenses under this subsection:

(a) services not provided and billed by a hospital with a hemodialysis program approved by the carrier;

SALARIED HEALTH CARE PROGRAM

App. A, III. A.3.b.(3)(b)

(b) reimbursement to individuals trained and assisting in the dialysis procedure;

(c) electricity or water used in operating the dialyzer;

(d) installation of electric power, a water supply, or a sanitary waste disposal system in conjunction with installing the dialysis equipment;

(e) physician's services, except to the extent the physician is reimbursed by the hospital for administration and overall supervision of the program;

(f) transfer of the dialyzer to another location in the enrollee's residence;

(g) services performed prior to the effective date of the home hemodialysis program; and

(h) services provided by an agency or organization providing "back-up" assistance in home hemodialysis, including the services of hospital personnel sent to the enrollee's home, or of other persons under contract with the hospital.

4. Limitations and Exclusions

a. Coverage for hospital admissions and services is only for the period which is medically necessary for the proper care and treatment of the enrollee, subject to the maximum benefit period and other applicable Program provisions. As a condition of continued hospital coverage, the carrier may require written verification by the physician in charge of the case of the need for services. For purposes of this subsection and subsection 4.b., below, the carrier shall review the severity of the

App. A, III. A.4.a.

patient's illness and the nature and intensity of services required/provided and, based upon such review, shall have discretionary authority to interpret, apply and construe these provisions of the Program. The carrier's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious.

b. Coverage does not include hospital services related to domiciliary, custodial, convalescent, nursing home, or rest care.

c. Coverage does not include hospital services consisting principally of dental treatment or extraction of teeth, except when either multiple extractions or the removal of one or more unerupted teeth is performed under general anesthesia and a concurrent hazardous medical condition exists.

d. Coverage does not include inpatient hospital services when the care received consists principally of observation or diagnostic evaluations, inpatient physical, functional occupational or speech therapy, x-ray examinations, laboratory examinations, electrocardiography or basal metabolism tests, ultrasound studies, nuclear medicine studies, weight reduction by diet control with or without medication, or environmental control.

e. Coverage for hospital services does not include services of physicians, oral surgeons, or services covered elsewhere in this Appendix, such as x-ray examination or therapy, electrocardiography, cobalt, or ultrasound studies.

f. The enrollee must give notice of coverage to any hospital at the time of admission. If notice is not given at that time, the enrollee may be liable for a portion of charges incurred.

g. If an enrollee cannot obtain admission to participating or nonparticipating hospitals, the carrier may pay the enrollee an amount not to exceed $65 for the expense

App. A, III. A.4.g.

of nursing and other services and supplies, restricted to the equivalent of hospital care made necessary by the illness or injury. The payment shall be full satisfaction of all obligations of the carrier and the participating hospitals to furnish hospital service for the disability for which admission was sought; provided, however, that if the admission is for the care of contagious or epidemic disease, or injury due to war, declared or undeclared, the Corporation, the carriers and the participating hospitals are under no obligation or liability under this Program.

h. Hospital coverage does not include facility charges for care received in an urgent care center.

i. Hospital coverage does not include facility charges for care received in a freestanding ambulatory surgery center, unless such center meets Program standards and is approved by the carrier.

j. Hospital coverage does not include facility charges related to refractive eye surgery (e.g., radial keratotomy, corneal sculpting or similar surgical procedures to correct vision), sterilization reversals or non-covered plastic, cosmetic, or reconstructive surgery.

k. Hospital coverage does not include positron emission tomography (PET) scanning services.

l. Coverage for hospital services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

B. Skilled Nursing Facility Coverage

1. Conditions of Benefit Payments
All skilled nursing admissions should be predetermined with the carrier.

An enrollee is eligible for benefits for covered expenses incurred in a skilled nursing facility only if the following conditions have been met:

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App. A, III. B.1.a.

a. The admission to the skilled nur ng facility commences on or after t enrollee's effective date of c age under this Program.

b. The admission has been approv by the carrier and the enrollee is a itted to the skilled nursing facility . the order of a physician who certifies that the enrollee requires the type of care available at the facility.

c. The enrollee has benefit days available under the skilled nursing facility benefit period (see App. A, II.B.).

d. The care received by the enrollee consists of definitive medical, nursing, or other paramedical care.

2. Coverages

a. Upon admission to a skilled nursing facility approved by the carrier, an enrollee is entitled to receive the following services when prescribed by the physician in charge of the case and when provided and billed by the facility:

(1) Semiprivate room, general nursing service, meals, and special diets;

(2) Use of special treatment rooms;

(3) Routine laboratory examinations;

(4) Physical, speech, or functional occupational therapy when medically necessary for the treatment of the enrollee (see App. A, III.C.);

(5) Oxygen and other gas therapy;

(6) Drugs, biologicals, and solutions used while the enrollee is in the facility;

App. A, III. B.2.a.(7)

(7) Gauze, cotton, fabrics, solutions, plaster, splints and other materials used in dressings and casts; and

(8) Durable medical equipment (see App. A, III.I.).

b. Medical care in skilled nursing facilities: Coverage is provided for medical care approved by the carrier in a skilled nursing facility by the physician in charge of the case. Care is subject to the 730-day benefit period maximum. Medical care in a skilled nursing facility for the treatment of tuberculosis or substance abuse is not covered.

3. Limitations and Exclusions

a. Skilled nursing facility admissions and services are covered only when the services are medically necessary. As a condition of continued skilled nursing facility coverage, the carrier may require written verification by the physician in charge of the case of the need for services. For the purposes of this subsection and of subsection 3.b., below, the carrier shall review the severity of the patient's illness and the nature and intensity of the services required/provided and, based upon such review, shall have discretionary authority to interpret, apply and construe these provisions of the Program. The carrier's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious.

b. Coverage is not provided for care which is principally custodial or domiciliary or for care of tuberculosis.

c. Coverage for skilled nursing facility services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

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App. A, III. C.

C. Physical, Functional Occupational and Spe .h Therapy and Car .iac Rehabilitation Coverage

1. Conditions of Benefit Payments
An enrollee is eligible for benef for covered physical, functional occupational .d speech therapy and cardiac rehabilitati expenses only if the following conditions have been met:

a. Outpatient services are received on or after the enrollee's effective date of coverage in this Program or, for inpatient services in a hospital or skilled nursing facility or for services provided through a home health care program, the admission commences on or after the enrollee's effective date of coverage in this Program;

b. Services are approved by the carrier, prescribed by the physician in charge of the case, and provided or supervised by a physician (other than a limited-practice physician) or by a registered and licensed physical, occupational or speech therapist for the specific therapy prescribed;

c. Services are provided and billed by a physician (other than a limited-practice physician) or a hospital, or a freestanding outpatient physical therapy facility, home health care agency, skilled nursing facility, or independent therapist approved by the carrier; and

d. Benefits are available during the benefit period for covered hospital or skilled nursing facility inpatient care.

2. Coverages

Services are covered as follows:

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App. A, III. C.2.a.

a. Physical Therapy and Functional Occupational Therapy

(1) During a covered admission to a hospital or skilled nursing facility, an enrollee is entitled to receive physical and functional occupational therapy to the extent medically necessary for the treatment of the condition for which the enrollee is admitted. If rehabilitation care is prescribed and approved, the rehabilitation program is expected to include, at a minimum:

(a) Medical care and supervision by a physician with specialized training and/or experience in rehabilitation, with 24-hour per day physician availability in addition to physician evaluation of the patient at least three times per week;

(b) The active involvement in the patient's care of a nurse with specialized training and/or experience in rehabilitation nursing (including 24-hour immediate, on the premises, availability of a registered nurse with specialized training and/or experience in rehabilitation nursing);

(c) Social work services;

(d) Physical therapy services;

(e) Plus one or more of the following:

(i) occupational therapy;

(ii) speech therapy;

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App. A, III. C.2.a.(1)(e)(iii)

(iii) psychological services;

(iv) prosthetic and/or orthotic fabrication and fitting.

(2) Enrollees are entitled to receive physical therapy and functional occupational therapy provided through an approved home health care agency. When special equipment not easily made available in the home is required, an enrollee is entitled to coverage for such services in a hospital or freestanding outpatient physical therapy facility participating with the home health care agency when related to the condition for which the enrollee was admitted to the home health care program.

(3) Physical therapy and/or functional occupational therapy are covered on an outpatient basis when performed to restore or improve musculoskeletal function.

b. Speech Therapy

(1) During a covered admission to a hospital or skilled nursing facility, an enrollee is entitled to receive speech therapy on the same basis as described in subsection 2.a.(1) above.

(2) Enrollees are entitled to receive speech therapy provided through an approved home health care agency.

(3) Restorative speech therapy (speech pathology) is covered on an outpatient basis when related to the treatment of an organic medical condition or to the immediate post-operative or convalescent state of the enrollee's illness. Speech therapy is not covered for long-standing, chronic conditions, or inherited speech abnormalities except as set forth in subsection b.(4) below.

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App. A, III. C.2.b.(4)

(4) Speech therapy for congenital and severe developmental speech disorders is covered when not available through other public agencies (e.g., state or school).

(a) In order to be covered, the enrollee must be diagnosed as having a severe communicative deficit as defined by Program standards.

(b) Speech therapy is not covered for:

(i) educational learning disabilities (e.g., dyslexia);

(ii) deviant swallow or tongue thrust;

(iii) mild developmental speech or language disorders;

(iv) congenital deafness;

(v) elimination of a lisp, or similar defect in articulation; or

(vi) improving speech that is not fully developed.

(c) Initial and interim patient assessment to determine severity of condition, potential for improvement, progress and/or readiness for discharge from treatment is considered part of the overall treatment program and is a covered service when accompanied by treatment.

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App. A, III. C.2.b.(4)(d)

(d) Steady improvement as a consequence of treatmen must be documented in periodic terim reports. Such documen on must be available to the ca i r upon request.

c. Cardiac Rehabilitation

(1) During a covered admission to a hospital or skilled nursing facility, an enrollee may receive cardiac rehabilitation on the same basis as therapy described in subsection 2.a.(1) above.

(2) Enrollees may receive cardiac rehabilitation on an outpatient basis provided through a hospital or performed or supervised and billed by a physician. The payment of benefits for cardiac rehabilitation on an outpatient basis is limited to services provided during the six-month period immedia-ly following acute myocardial infarct. initial diagnosis of angina pectoris, or certain heart surgeries.

3. Limitations and Exclusions

a. Covered expenses will not include and benefits are not payable for:

(1) physical, functional occupational and/or speech therapy services if:

(a) such services are provided without expectation that e condition will improve in a easonable and generally predict e period of time.

b: improvement does not occur, as documented in the pa ent's record on a periodic basis.

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App. A, III. C.3.a.(1)(c)

(c) progress is no longer being made or the previous level of function has been restored;

(2) physical therapy and/or functional occupational therapy provided solely to maintain musculoskeletal function;

(3) occupational therapy which is not functional in nature;

(4) inpatient admissions which are principally for physical, functional occupational and/or speech therapy or for cardiac rehabilitation;

(5) manipulation, adjustment or massage of the musculoskeletal system;

(6) vision therapy or training;

(7) cognitive rehabilitation which includes, but is not limited to, vocational rehabilitation, recreational therapy, learning exercises for retraining in routine activities of life or aspects of cognitive functioning such as concentration, organizational skills, information processing, memory, thinking, and problem solving;

(8) day, night or residential rehabilitation programs;

(9) services which could be performed by an untrained, unlicensed person, by the enrollee, or by a member of the enrollee's family;

(10) isokinetic testing or treatment;

(11) debridement and cleansing with whirlpool for first or second degree burns;

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App. A, III. C.3.a.(12)

(12) physical and/or functional occupational therapy for first and second degree burns.

b. Coverage for physical, functional occupational and speech therapy and cardiac rehabilitation is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

D. Home Health Care Coverage

1. Conditions of Benefit Payments

Home health care services are subject to predetermination by the carrier. An enrollee is eligible for benefits for covered expenses incurred for home health care services only if the following conditions have been met:

a. Admission to the home health care program commences on or after the enrollee's effective date of coverage in this Program;

b. The enrollee is referred to and accepted by a home health care agency that meets Program standards and is approved by the local carrier;

c. The services received are approved by the carrier, prescribed by the physician in charge of the case and provided and billed by an approved provider;

d. The physician in charge of the case certifies to the carrier that skilled home health care services are medically necessary for the care of the enrollee; and

e. The enrollee is essentially homebound for medical reasons and physically unable to routinely obtain the needed medical services on an outpatient basis without special assistance.

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App. A, III. D.2.

2. Coverages

a. The following services are covered when provided on a part-time or intermittent basis during a home health care visit and billed by a home health care agency approved by the carrier:

(1) General nursing services;

(2) Physical therapy and speech therapy (may be provided and billed by a hospital outpatient department or a carrier-approved physical therapy provider under limited circumstances - see App. A, III.C.2.);

(3) Social service guidance, dietary guidance, and functional occupational therapy; and

(4) Services by a home health aide employed by an approved home health care agency. To be eligible for home health aide service, the enrollee must be receiving one of the services in (1) or (2) above, and it must be determined by the home health care agency and the carrier that the enrollee could not be treated under this subsection without the home health aide service.

b. For the purposes of this subsection III.D.:

(1) A home health care visit consists of a visit

(a) to the enrollee's home by any member of the home health care team for the purpose of providing necessary professional service;

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App. A, III. D.2.b.(1)(b)

(b) to the enrollee's home by a home health aide for the purpose of providing covered home health aide services as described in subsection 2.a.(4) above; or

(c) by the enrollee to a hospital or skilled nursing facility or approved physical therapy provider as an outpatient for speech evaluation or physical therapy when required equipment is not easily available for home use;

(2) "part-time care" means:

(a) up to and including 28 hours per week of skilled nursing and home health aide services combined, for less than eight hours per day; or

(b) up to 35 hours per week of skilled nursing and home health aide services combined, for less than eight hours per day, subject to individual review and approval by the carrier based on diagnosis, prognosis and documented improvement in the patient's condition; and

(3) "intermittent care" means:

(a) part-time care as described in subsections (2)(a) and (b) above, which is provided on less than a daily basis; or

(b) up to eight hours per day of skilled nursing and home health aide services combined, delivered on a daily basis, for a temporary period not to exceed one month, subject to individual carrier review and approval based on diagnosis, prognosis and documented improvement in the patient's condition.

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App. A, III. D.2.c.

c. The following services are covered when provided and billed by an approved provider:

(1) Laboratory tests;

(2) Drugs, biologicals, and solutions; and

(3) Medical supplies which are essential in order to effectively administer in the home the medical regimen ordered by the physician. Supplies include items such as bandages, dressings, splints, hypodermic needles, catheters, colostomy appliances, and oxygen. When covered home health care services are being provided, medical supplies used in the home for the patient's care will be covered under this section, even if used during a portion of the day or week when nursing services are not covered.

3. Limitations and Exclusions

a. Coverage for home health care services is available only when the services are medically necessary. As a condition of continued home health care coverage, the carrier may require written verification by the physician in charge of the case of the need for services. The carrier shall have discretionary authority to interpret, apply and construe this provision of the Program. The carrier's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious.

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App. A, III. D.3.b.

b. Coverage under this subsection does not include supplies such as elastic stockings, personal comfort or personal hygiene items or equipment, or supplies and appliances which may be covered under the durable medical equipment and prosthetic or orthotic appliance provisions (such as hospital beds, oxygen tents, walkers, wheelchairs, or orthotics).

c. Coverage under this subsection does not include physician services, private duty nursing services or housekeeping services.

d. Coverage under this subsection does not include skilled nursing services and home health aide visits when the care exceeds the part-time or intermittent levels.

e. Coverage under this subsection does not include home uterine monitoring.

f. Coverage under this subsection does not include charges for travel time.

g. The maximum amount of reimbursable expense for home health care services under this subsection is limited to the amount which would be reimbursable for similar care rendered in a skilled nursing facility.

h. Coverage for home health care services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

E. Surgical and Medical Coverage

1. Conditions of Benefit Payments
An enrollee is eligible for benefits for expenses incurred for surgical and medical covered services only when the following conditions have been met:

a. Services are received on or after the enrollee's effective date of coverage in this Program;

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App. A, III. E.1.b.

b. Services are approved by the carrier, when necessary; and

c. Services are received prior to the termination date of the enrollee's coverage, except that services received during hospital admissions which commence prior to such termination date will be covered subject to other provisions of this Program.

2. Payment of Services

a. The carrier(s) will make payment according to a fee schedule, capitation schedule, or reasonable and customary charges.

b. A carrier will make the benefit payments directly to the provider for services performed or materials furnished by such provider, or directly to the enrollee if appropriate.

c. The carriers shall have discretionary authority to interpret, apply and construe these reimbursement provisions of the Program. A carrier's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious. Except for reimbursement for off-panel services received by a PPO option enrollee without referral, the carrier will defend its determination of the fee, capitation rate or reasonable and customary charge if a provider claims an amount in excess of the carrier's determination from the enrollee and there is no payment or prior written agreement between the patient and the provider regarding the amount of the provider's charges.

d. Certain hospital-based physician services billed by a hospital will be paid directly to the hospital by a carrier according to the carrier's agreement with the hospital.

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App. A, III. E.3.

3. Coverages

Except as otherwise indicated, the foll ng services are covered:

a. Surgery: Subject to the limita as listed below, surgical service: consisting of generally accepte operating and cutting procedures for the necessary diagnosis and treatment of diseases, injuries, fractures, or dislocations, are covered when performed by the physician in charge of the case.

Surgical services include usual, necessary, and related preoperative and postoperative care performed in or out of the hospital.

(1) Plastic and reconstructive surgery is limited to the correction of congenital anomalies and conditions resulting from accidental injuries or traumatic scars, to the correction of deformities resulting from cancer surgery or following medically necessary mastectomies (including medically necessary mastectomies resulting from cancer or fibrocystic disease), and to blepharoplasties when there is visual impairment.

(2) Dental surgery is limited to multiple extractions, removal of one or more unerupted teeth, alveoloplasty, or gingivectomy, and is covered only when performed for a hospital inpatient when a concurrent hazardous medical condition requiring hospitalization exists. Surgical procedures to excise tumors or cysts of the oral cavity, to correct fractures of facial or jaw bones, dislocations and disorders of oints, or to correct accidental inju are not considered dental surgery and are considered in accordance with the general surgery provisions above.

[illegible] [illegible]

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App. A, III. E.3.a.(3)

(3) For medically recognized human organ or tissue transplants [see App. A, III.A.2.w.(5)] from a living or cadaver donor to a transplant recipient which requires surgical removal of a donated part, benefits for services as listed and limited in this subsection (including laboratory services for evaluation tests to establish a potential donor's compatability and suitability) will be covered in the same manner as under Section III.A.2.w.

Payments will be reduced by any amount payable from other sources, such as foundations, grants, governmental agencies or programs, research or educational grants and charitable organizations.

(4) Surgical procedures for sterilization of male and female enrollees irrespective of medical necessity are covered. Sterilization reversals are not covered.

(5) Laser surgery is covered if the alternative cutting procedure is covered. The maximum benefit payable for laser surgery is the reasonable and customary charge for the alternative cutting procedure.

b. Hemodialysis: Services are covered only when performed by a physician in a facility meeting Program standards and approved by the local carrier or in the enrollee's home.

c. Anesthesia: Services for the administration of anesthetics are covered, when provided by a physician, other than the operating physician, and when required by, and performed in conjunction with, another covered service. Anesthesia

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App. A, III. E.3.c.

services include the administrati of anesthesia by a lay or nurse anes etist in the employ of the physician wh authorizes the services of the a: hetist and who is available for immedia· attendance. Services of an ind ei.dent certified registered nurse anes .ietist (CRNA) are eligible for coverag only when (1) services are provided under the direct supervision of a physician, (2) the CRNA is approved by the carrier and meets Program standards, and (3) the various providers involved in the care agree with the carrier's reimbursement policies/ arrangements.

Administration of local anesthetics is not covered. Anesthesia service provided by an employee of a hospital is covered only under Section III.A.2.c.

d. Technical surgical assistance: Services by a physician who actively assists the operating physician are covered when medically necessary and when related to covered surgical or maternity services. I. order for the services of the assistant surgical physician to be covered, it must be certified that the services of interns, residents, or house officers were not available at the time.

e. Maternity care: Obstetrical services of a physician, including usual prenatal and postnatal care, are covered. For each pregnancy, coverage is also provided for routine prenatal laboratory examinations which are performed in connection with normal maternity care. Coverage includes:

(1) the examination of a newborn child by a physician other than the delivering physician or the physician administering anesthesia during delivery; and

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App. A, III. E.3.e.(2)

(2) obstetrical services of a physician for an abortion.

f. Consultations: When requested by the physician in charge of the case, coverage is provided for the assistance of a physician in the diagnosis or treatment of a condition which requires special skill or knowledge. This coverage does not include phone consultations or staff consultations required by a facility.

g. Chemotherapy: Coverage for chemotherapy is provided under App. A, III.A.2.e. for inpatient care and under App. A, III.A.3.a.(3) for outpatient care. Chemotherapy administered in a physician's office is covered on the same basis as outpatient and excludes services which are research, investigational or experimental in nature (e.g., high dose chemotherapy for a patient with solid tumors of the brain, breast, colon, lung or skin).

h. Extra-corporeal shock wave lithotripsy (ESWL): Coverage is provided for services rendered in a carrier-approved facility meeting Program standards.

i. Therapeutic radiology: Coverage is provided for treatment of conditions by x-ray, radium, radon, external radiation, or radioactive isotopes (e.g., cobalt), and includes the cost of materials provided which are not supplied by a hospital.

j. Diagnostic radiology: Coverage is provided if approved by the carrier as required, for diagnosis of any condition, disease, or injury by x-ray, ultrasound, isotope examination, computerized axial tomography (CAT scans) for the head and body and magnetic resonance imaging (MRI) as follows:

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App. A, III. E.3.j.(1)

(1) Computerized axial tomography is covered for diagnostic examinations of the head and body when ordered by a physician and performed on approved equipment in accordance with program standards.

(2) Digital subtraction angiography is covered if performed on hospital based equipment.

(3) Magnetic resonance imaging (MRI) coverage is provided in accordance with Program standards, which include diagnosis restrictions and the use of carrier-approved facilities.

k. Laboratory, pathology and other services: Coverage is provided if approved by the carrier for laboratory and pathological examinations for the diagnosis of conditions, diseases, or injuries or for performing covered well child care services and physical examinations. In addition to examinations of blood, tissue, and urine, diagnostic laboratory and pathology coverage includes laboratory procedures such as electrocardiograms, electroencephalograms, electromyograms, and basal metabolism tests.

(1) Routine laboratory services in connection with normal maternity care are covered according to the provisions of Section III.E.3.e.

(2) Hearing aid evaluation tests are covered only under Section III.H. of this Appendix.

(3) Audiometric examinations may be covered, but are subject to the exclusions of Appendix A, III.H.5.a., d., e., g., h., i., j., k., and l.

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App. A, III. E.3.1.

1. Physician medical visits: Coverage is provided for medical visits by a physician when rendered in the physician's office, the home, a hospital, or a skilled nursing facility for the examination, or diagnosis and treatment of any condition, disease or injury subject to the provisions below.

   (1) Inpatient medical care is covered when provided by the physician in charge of the case. Services of a physician who is treating a condition unrelated to the reason for the admission may also be covered.

   (2) Treatment rendered in or at a hospital is covered only when provided by a physician who is not an employee of the hospital.

   (3) Well child care is covered for enrollees six years of age or younger.

   (4) Routine physical examinations are covered for enrollees over six years of age and are limited to one each calendar year.

   (5) Physician medical visit coverage does not include services or separate charges for the following (although some of the items may be covered under other provisions of the Program):

      (a) mental health or substance abuse treatment;

      (b) prenatal and postnatal care;

      (c) immunizations;

      (d) routine eye examinations;

      (e) insurance, employment and premarital examinations;

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(f) manipulation, adjustment or massage of the musculos eletal system;

(g) allergy testing, treatment or injections;

(h) weight control;

(i) acupuncture; or

(j) services provided by non-physician practitioners, e.g., Physician Assistants, Christian Science practitioners, etc.

m. Immunizations and injections: Coverage is provided for medically recognized immunizations and injections as approved by the carrier.

(1) Serum is covered only when it is not supplied by a health department or other public agency.

(2) Vitamin and iron injections are covered only when required and necessary for diagnosed illness.

(3) Injections for chelation therapy are not covered, unless they meet Program standards as to diagnosis and the nature of the service(s) performed. Chelation therapy by means other than injection may be covered under other provisions of the Program.

(4) Allergy injections are not covered.

(5) Injections covered under another Section of this Appendix (e.g., chemotherapy) are not covered.

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n. Foot care: Coverage is provided for treatment of injuries and/or infections of the feet. Routine foot care (e.g., cutting, paring, debridement and curettement of nails, corns, callouses and other hyperkeratotic or benign lesions and treatment of mycotic toe nails) is covered only for enrollees with a confirmed diagnosis of diabetes or peripheral vascular disease and is subject to Program standards regarding frequency.

o. Screening examinations: Coverage is provided in accordance with the provisions of subsections E.3.j. and k., above, for appropriate examinations and procedures prescribed by a physician and performed solely for early detection of a pathological condition in an otherwise asymptomatic individual. However, the deductible and copayment provisions otherwise applicable to services performed for enrollees of particular options, under Article II, Section 4 of the Program, do not apply to:

(1) laboratory and pathological services for one routine Papanicolau (PAP) smear per enrollee per calendar year to detect cancer of the female genital tract,

(2) one proctoscopic exam without biopsy performed within each three calendar year period after age 40 is attained, or

(3) routine screening mammograms which are not in excess of a schedule which meets Program standards and is applicable to enrollees age 40 and older.

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